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ABSTRACT

These background papers and recommendations from a mini-conference on the consumer problems of older Americans and new directions that government and business should take to protect the consumer rights of the elderly address the following areas: credit, food, insurance, investments, prescription drugs and medical appliances, and primary health care providers. Examined first are access to credit, credit histories, electronic fund transfers, deregulation of banking, alternative mortgage instruments, security investments, coordination of billing/pension cycles, and the television and appliance rental industry. Following a discussion of food price inflation, advertising, and information, the following areas are investigated: consumer/nutrition education, access to food, layout and services in the store, and eating out. Various types of insurance are covered, including auto, health, and life insurance. Investigated next are real estate investments, business opportunities, inflation investments, and financial counseling. Prescription drugs and medical appliances for hearing and vision care are dealt with. In a final section on primary health providers denturism and nurse practitioners are considered. (MN)

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CON$UMER PROBLEMS OF OLDER AMERICANS

New Directions for Government and Business

Background Papers and Recommendations from a Mini-Conference for the White House Conference on Aging

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INTRODUCTION

Persons over the age of 65 now comprise more than 11 percent of the U.S. population, and their ranks are expected to grow to at least 13 percent by the year 2000, and 20 percent by 2030. These demographic considerations alone indicate the growing importance of the elderly consumers. Yet analysts both in the public and private sector who assume that the older population forms a homogenous, stereotypical group run the risk of serious error. Some marketing specialists, for example, portray all older consumers as members of a new leisure class, affluent with large amounts of disposable income, a ready market for the canny client or entrepreneur. At the other end of the scale, some find it in their interest to depict the older population as generally poor, physically impaired, or institutionalized.

Both of these portrayals represent exaggerations which correctly describe only very small portions of the older population. The elderly group includes members of all economic classes. They are working, retired or sometimes unwillingly unemployed. They are heads of households and dependents; physically robust and disabled; highly educated and hardly educated.

But in spite of their diversity, it is also important to recognize that older persons do have legitimate and definable consumer needs which must be addressed by policy makers in private industry and the public sector. For instance, about forty-five percent are limited in their major activities because of some type of chronic physical condition. Since only five percent of the elderly live in nursing homes, the great majority of those with physical limitations are self-sustaining and responsible for themselves in the marketplace. A primary consumer need is for sound consumer education materials which inform them about such necessary products and services as wheelchairs, generic medicines, or hearing aids.

Other older persons who do not suffer physical disabilities may have entirely different consumer concerns, but the need for informative consumer materials remains constant. To serve older consumers, it is incumbent upon responsible business persons to provide them readable, timely and understandable materials which will help them assess products and services. For many businesses, this may involve producing printed materials in a type size large enough for the visually impaired since visual problems increase dramatically with age. For grocers, it may mean item pricing or putting shelf prices high enough so that people don't have to stoop low to see them. For public agencies at the federal, state and local levels, it may mean not only producing their own consumer education materials, but monitoring or regulating business practices to ensure that the elderly get the protection they need in the marketplace.

Research has shown that many older persons who established their consumer habits forty or fifty years ago have a marked disinclination to file consumer complaints, and that if they do complain, they tend to do so in the least assertive manner. It appears also that some older consumers are less likely than younger people to perceive unfair business practices.

For these reasons, business, public and private agencies at all levels which are charged with protection of consumer rights have a special responsibility for policing the marketplace on behalf of the elderly. They may also need to review their complaint mechanisms to make sure they are suited to the needs of older people.

To address older persons' consumer needs and to call special attention to their concerns, the National Retired Teachers Association and American Association of Retired Persons convened a White House Conference on Aging Mini-Conference on Consumer Problems of Older Americans,

January 29-30, 1981. Over sixty expert delegates from aging, consumer, and private organizations, government, and the academic community participated. Discussion focused on six consumer topics: credit, food, insurance, investments, prescription drugs and medical appliances, and primary health care providers. The following descriptions summarize the material on these topics dealt with in this book's six chapters.

Credit

Credit has become the key to full participation in the benefits of our society. To many older persons, however, the idea of using credit for the purchase of goods and services is still foreign. For the elderly to be unfamiliar with the benefits and rights, as well as the responsibilities and pitfalls of credit transactions, can put them at a distinct disadvantage in the marketplace. Many of the elderly continue to be treated unfairly in the credit market, despite legislative efforts such as the Equal Credit Opportunity Act.

Food

Americans over age 65 spend roughly 22 percent of their before-tax income on food, compared with about 17 percent for those under 65. Major issues concerning food and the elderly include food price inflation, food advertising, food information, consumer nutrition information, access to food, store layout and services, and eating out.

Insurance

The most troublesome form of insurance facing the elderly is health insurance. Since the enactment of Medicare involved compromise leaving gaps for private health insurance to fill, the sale of Medicare supplement policies has become a big business, which is largely unregulated. Many elderly persons have been sold far more supplementary coverage than needed, and many of these policies have been extremely poor values for their cost. State regulation, consumer education and complex policy language are also major issues in this area.

Investments

Fraudulent investment schemes and deceptive sales methods strike particularly hard at older people. The elderly are often caught in the financial vise created by the combination of declining income and rising expenses. The economic difficulties caused by this situation frequently tempt the elderly to respond to promotions offering the promise of quick financial gain.

Prescription Drugs and Medical Appliances

The elderly are highly disproportionate consumers of prescription drugs and medical appliances. Persons over age 65 comprise 11 percent of the population, but account for 25 percent of the national drug bill. Yet, because so many older persons are on low or fixed incomes, they may be least able to afford the cost of needed prescription drugs or medical appliances.

Primary Health Care Providers

Availability, affordability and accessibility of quality health care services is of particular concern to the older population. The aged population is expected to increase from its current 11.2 percent to 17.2 percent by 2025. This growth will create the need for more primary health care delivery systems designed to provide care to the elderly in our society.

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The selection of delegates for the conference was guided by the advisory committee formed for this mini-conference. The advisory committee included representatives of the following organizations:

American Association of Homes for the Aged
Asociacion Nacional Pro Personas Mayores
Consumer Federation of America
Gray Panthers
National Association of Area Agencies on Aging
National Association of Consumer Agency Administrators
National Association of State Units on Aging
National Caucus on the Black Aged
National Consumers League
National Council on Aging
National Council of Senior Citizens
Society of Consumer Affairs Professionals in Business
Society of Consumer Affairs Professionals in Business, Washington, D.C. Chapter
and
Esther Peterson, former Special Assistant to the President for Consumer Affairs and former Director, U.S. Office of Consumer Affairs

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Avon Products, Inc.
Citicorp N.A.
Food Marketing Institute

It is only through the efforts and assistance of all these individuals and organizations that the mini-conference was possible.

While this book does not necessarily reflect the particular policy of any of the organizations mentioned above, it represents an important step in discovering new solutions to consumer issues of tremendous importance to all older Americans.

Thomas C. Nelson
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CREDIT

INTRODUCTION

Problems involving credit can be particularly serious for the elderly. The use of credit cards and installment loans for buying goods is a relatively recent phenomenon, and many older buyers are being confronted for the first time with the concept that buying on credit is both acceptable and necessary. For many older Americans, the idea of buying goods and services on credit is a foreign one, since many of them have paid most of their obligations in cash rather than over a period of time. Hence, many older people have neither credit ratings nor experience with buying on credit.

Credit has become the key to full participation in the benefits of our society— for the elderly as well as younger consumers. Few consumers are able to make major purchases, such as a house or a car, for cash, and now everything from toothpaste to education is bought on credit. The ubiquitous credit card has become a national identification card, signifying that the holder is a responsible, trustworthy individual. Consumer debt in the United States has grown so large that consumers now owe almost $1.2 trillion on their homes, $280 billion in installment debt, and another $64 billion in non-installment debt. Consumers are reported to have 600 million credit cards and to spend nearly 23 cents out of every dollar they take home to pay off their indebtedness. The use of credit cards and other credit buying provides convenience, helps to ensure personal safety by allowing consumers not to carry cash, and provides a hedge against inflation by allowing goods to be purchased at today's prices. For the elderly to be unfamiliar with these benefits and rights, as well as the attendant responsibilities and pitfalls of credit transactions, can put them at a distinct disadvantage in the marketplace.

In spite of some inexperience with credit, more and more elderly persons have begun using credit cards. While the number of families using credit cards increased almost 20 percent between 1970 and 1977, the number of people over age 65 using credit cards increased by more than 50 percent and the number of people over age 75 using credit cards increased by over 67 percent.

Several laws have been enacted to protect consumers' rights. A number of these laws directly affect the elderly. The Equal Credit Opportunity Act (ECOA) prohibits creditors from discriminating against the elderly in any aspect of a credit transaction. Despite the Act's prohibition of age discrimination, many elderly continue to be treated unfairly in the credit market. Some creditors simply do not comply with the law by refusing to grant credit to the elderly, or offering credit to older applicants at terms so unfavorable that they are impossible to meet. Even creditors who do not blatantly discriminate against the elderly may inequitably limit access to credit for older citizens by basing decisions about their applications on the same criteria applied to younger applicants, even though such criteria put the elderly at a clear and unfair disadvantage.

What is most puzzling about these practices is that they are not only illegal or unfair, but they also make bad business sense. It is generally recognized that the elderly as a group repay loans at a higher rate than younger people. In a report submitted to Congress in 1976, it was noted that the older the applicant the better the repayment record. The report indicated that customers who are 65 and older have a repayment record approximately five times better than customers in the 21 to 24 year-old category, and twice as good as customers in the 35 to 44 year-old category.

Other credit laws which can affect the elderly include the Fair Credit Reporting

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Act (FCRA), the Electronic Fund Transfer Act (EFTA), the Truth in Lending Act (TILA), the Fair Credit Billing Act (FCBA) and the Fair Debt Collection Practices Act (FDCPA).

This section sets forth some of the major areas in which credit affects the elderly:

- access to credit
- credit histories
- electronic fund transfers
- deregulation of banking
- alternative mortgage instruments
- security interest
- coordination of billing/pension cycles
- TV and appliance rental industry

In many of these areas, considerable educational material is available to advise elderly consumers of their rights. In other areas such materials need to be developed. The underlying problem, however, is that information doesn't seem to be reaching the people who need it most. Although the elderly are sometimes treated unfairly in the credit marketplace, it appears that they don't complain through appropriate channels as much as younger consumers.

I. ACCESS TO CREDIT

The Problem

Creditors use various criteria to determine whether an applicant is creditworthy. They want to ensure that the applicant is both willing and able to repay the debt. Because the elderly often have different income levels, assets, spending patterns, and lifestyles than young and middle-aged persons, some criteria which are useful in predicting the likelihood of repayment by younger people may not accurately reflect elderly applicants' creditworthiness. Therefore, refusing to grant credit on the basis of such standards may not only be unfair to the elderly, it may also be an unwise business decision for the creditor.

The Issues

A. Income Verification

Another credit criterion which has an adverse impact on the elderly is the common requirement that an applicant's income be verified within a specific time period. Employment income is relatively simple to verify. But many older citizens are unemployed and receive their income from less accessible or responsive sources, such as the government. They may not be easily able to produce proof that they regularly receive such income. Therefore they may be turned down for credit for which they otherwise qualify. Central to this issue is the need to know the pervasiveness of the problem, methods to assist creditors to remedy the problem, and strategies to encourage prompt response from verifiers of non-employment income.

B. Life Expectancy

While it is permissible for a creditor to consider life expectancy tables in determining the likelihood of an applicant's repaying a loan, some creditors appear to use life expectancy factors as a means to limit the amount of or refuse credit to the elderly. Creditors may deny loans to older applicants outright because of fears that death of the applicant will prevent repayment of the loan or because a short life expectancy means that the creditor will get less repeat business from an elderly applicant. Creditors may also terminate or fail to renew a loan because of decreased life expectancy, or offer such onerous terms that an applicant cannot possible repay the loan on the terms offered.

Creditors frequently consult life expectancy tables to predict an applicant's creditworthiness without considering other relevant factors, such as whether the applicant's assets are sufficient for his estate to repay the loan if he dies. Creditors often use life expectancy tables as an indication of probability of default, rather than examining the *actual* default rates of elderly applicants in the past. This practice will probably continue despite the general recognition that the elderly as a group have a better payback record than younger peo-

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ple. This record should be used to educate the credit industry about the unfair effect of life expectancy considerations. Strategy options might include the potential costs and benefits of individual consideration based on health records if life expectancy is an issue.

C. Insurance

A problem which frequently confronts older borrowers is caused by the fact that insurance companies generally refuse to provide credit life insurance for persons over 70 years of age. Many creditors strongly urge borrowers to take out credit life insurance at the time a loan contract is signed, and there is evidence that a loan transaction involving insurance confers considerably increased profit to the lender. Since elderly applicants are not able to obtain credit life insurance, a creditor's incentive to lend to older applicants is diminished considerably. While the law specifically forbids the denial or termination of a loan account because of insurance unavailability, it leaves open the possibility that a creditor would vary the terms and conditions of a loan based on the unavailability of credit life insurance because of age. This results in some creditors granting loans to the elderly only for very short terms, such as three months, which effectively denies a loan to many applicants who do not have the resources to repay the loan within such a short period.

D. Employment

Some creditors, such as finance companies, require a credit recipient to be employed. This practice discriminates against the elderly, who are more likely to be retired and therefore unemployed. It fails to take into account that older nonemployed persons may have income from other sources sufficient to demonstrate their creditworthiness. Although requiring an applicant to be employed is a clear violation of the Equal Credit Opportunity Act, it continues to occur. Special attention must be paid to enforcement strategies to ensure creditors' compliance in this area.

E. Kinds of Assets

The kinds of assets that creditors consider in determining whether to grant credit can unfairly limit older persons' access to credit. For example, mortgage lenders generally consider applicants' cash income, rather than the total value of their assets. Consequently, older applicants, whose cash flow income is likely to come from non-employment sources and thus be less substantial than that of younger, employed applicants, may be turned down for credit even if they have other assets such as stocks and bonds which should enhance their creditworthiness. Policies might be developed to encourage and/or require creditors to consider assets other than income for elderly applicants.

F. Debt to Income Ratio

Many mortgage lenders require that home buyers' mortgage payments not exceed a specified amount of their gross income. This debt to income ratio is considered a predictor of the buyer's ability to meet the mortgage payments. Mortgage lenders generally apply the same debt to gross income standards to all applicants. This practice ignores the probability that older applicants' income is more likely to come from nontaxable sources than younger persons', and that the elderly may have more conservative spending patterns than younger people. Therefore, elderly applicants may be able to reasonably afford the allocation of a larger percentage of their gross income to mortgage payments. Creditors could be encouraged or required to apply different debt to income standards to the elderly, but more needs to be known about potential costs and benefits to creditors if different standards for the elderly are to be used.

II. CREDIT HISTORIES

The Problem

Elderly people who apply for credit are often rejected because they have no credit history at a credit bureau. Many elderly have no credit history because they have elected to save their money and pay cash rather than buy on credit. Others, particularly women, may have credit histories which have not been reported in their own names, so that no record exists at credit bureaus.

The Issues

A. Lack of Credit History

A "Catch 22" of obtaining credit is that it is difficult to get credit unless you have had credit. A history of timely payments on a number of consumer credit accounts gives a credit grantor confidence that the applicant will be a good credit risk. By contrast, creditors generally refuse to extend credit to applicants who do not have a credit history. The elderly should know that it is important to establish and maintain modest lines of credit in order to ensure that credit histories are available when needed.

B. Old Credit History No Longer Reported

Older people who have borrowed money in the past may have paid off all their loans several years ago. If they list repaid lenders as credit references when they apply to a new creditor, the creditor may not be able to verify their repayment history, because many lenders appear to retain loan records for only a short time after the loan is paid off. Additionally, credit bureaus often purge favorable information from consumers' files after seven years or less, although federal law permits them to retain such information indefinitely. The elderly need to ensure that relevant past histories are retained in the credit reporting system. Legislation may be necessary to require that "old" credit histories be retained by creditors and/or reported by credit bureaus, and cost/benefit issues of such actions need to be examined.

C. Credit Histories Not Reported

One of the many problems that older women confront upon the death of a husband is the loss of their credit accounts. Many widows find that credit accounts they have shared for years with their husbands are suddenly terminated when their husbands die, and they are unable to qualify for accounts in their own names because they have no independent credit history. This sudden loss of credit, at a time when credit may be most needed to handle large expenses and delays in benefit payments, can create tremendous additional emotional strain and may precipitate a financial crisis.

Although the law generally permits a creditor to close a shared account upon the death of one spouse, the surviving spouse may reapply for individual credit and has the right to rely on the credit history of accounts shared with the late spouse, even if the accounts were listed solely in the spouse's name. Some creditors will automatically extend individual credit to a widow (or widower) upon request if there is a good payment record on the shared account, but this practice is not required by law.

A woman who has or had joint credit accounts with her husband or late husband may have no credit history in her own name, since it was the practice of creditors, prior to the Equal Credit Opportunity Act, to report information only in the husband's name. The law now requires that creditors report payment histories in the name of each spouse who is contractually liable for or who is authorized to use an account. Women should contact their creditors to make sure that current accounts are being reported in their names. For example, if a widow shared accounts with her late husband which were opened before June 1, 1977, and now are closed, she should contact her local credit bureau to check whether the accounts are listed in

her file. If accounts were reported only in her late husband's name, she should ask the bureau to have the closed accounts added to her file. The Fair Credit Reporting Act gives consumers the right to be told the contents of their credit files and to have inaccurate or incomplete information corrected. The elderly need to know how to ensure that both creditors and credit bureaus are reporting their credit histories.

The Equal Credit Opportunity Act also requires creditors to consider, upon request, the credit history a woman shares or shared with her husband or late husband, if she can show that it applies to her. Cancelled checks, for example, could show that she was responsible for paying monthly bills on time.

D. Relocation and Credit History

Even if an older person has acquired a credit bureau file that is complete and accurate, he can "lose" his good credit record if he moves to another city upon retirement. The credit bureaus at the new address are not likely to have files in his name. While it is possible for a credit bureau to obtain a credit report from a bureau in another city, it is often difficult and time consuming for the consumer to correct a credit file which may be many thousands of miles away. An elderly person planning to move to another city should review, for completeness and accuracy, his or her credit file at the local credit bureau before moving.

III. ELECTRONIC FUND TRANSFERS

The Problem

Electronic fund transfer (EFT) is a new method to make and receive payments which has begun to replace the check and cash as a payment mechanism. In EFT, the transfer of funds is accomplished electronically rather than manually through the exchange of paper instruments or currency. Common consumer-oriented EFT services include automatic teller machines, telephone bill-paying mechanisms, and direct electronic deposit of social security and other government benefit payments.

Direct deposit of government benefit payments is the EFT service most likely to affect the elderly. In this service, the consumer's account at a financial institution is credited directly by the Treasury Department for the amount of the payment. No check is used. Direct deposit brings both benefits and possible problems. Among the benefits of particular interest to the elderly are:

- no benefit check can be lost or stolen, because no check is involved in the transaction;
- no check can be delayed in the mails;
- consumers need not visit the financial institution personally to deposit checks; and
- consumers automatically have the use of funds from the day they are received in the financial institution.

However, direct deposit presents some new risks to elderly consumers. The Electronic Fund Transfer Act, passed in 1978, addresses some of these problems.

The Issues

A. Notification of Deposit

Because consumers no longer receive monthly checks, another system is needed to inform them of the amount of each payment. Unless the financial institution informs the consumer of the amount of each deposit, errors may go unnoticed. The EFT Act requires that consumers be notified of a direct deposit in one of four ways:

- by the payor (e.g., a pension plan);
- by the financial institution, whenever a deposit is made;
- by the financial institution, whenever an expected deposit is *not* made;
- by the financial institution providing a "readily available" telephone number for consumers to determine whether a payment has been received.

Financial institutions most often rely on the readily available phone number. While this is the easiest method for the financial institution, the phone number is not always toll free, and it puts the verification burden on the depositor. Most elderly are reluctant to use EFT since they prefer to have written verification of deposits.

The Social Security Administration, for example, does not provide a notice of each payment, so that elderly consumers must rely on their financial institution to tell them whether they have received a payment. There are questions yet to be answered about whether the four optional methods of giving notice provided by the law and regulation are adequate. Other forms of notification might need to be required, and should be examined in light of costs and benefits to consumers, financial institutions, and the government.

B. Compulsory Use of EFT

The EFT Act limits, but does not prohibit, compulsory use of EFT for the receipt of government benefits. Some government public assistance agencies have already attempted to *require* use of EFT to receive benefit payments. This is legal under the EFT Act as long as the consumer is not limited to one financial institution for receipt of the payment. Some consumers may not be able to afford maintenance charges on accounts, or may prefer to control the flow of funds in or out of their accounts themselves, rather than depend on financial institutions to do so. If the choice of financial institutions to receive EFT payments is limited, there may be a reduction in competition for accounts, leading to higher costs and reduced service. The limitation the EFT Act provides on compulsory use of EFT must be monitored to see that it ensures sufficient protection for the elderly who may not be able to afford accounts, or who prefer to rely on checks or cash.

IV. DEREGULATION OF BANKING

The Problem

The Depository Institutions Deregulation Act of 1980 can be expected to result in major changes in the competitive environment of financial institutions. Many of these changes will affect the elderly. Three of the major changes created by the Act are that it:

- eliminates, over a six-year period, present legal ceilings on the amount of interest a depository institution (bank, savings and loan association, mutual savings bank, or credit union) may pay on savings;
- permits depository institutions to offer interest-bearing checking accounts (called NOW accounts);
- requires banks to pay the cost of Federal Reserve Board check-clearing facilities, which were previously provided free of charge.

Taken as a whole, the changes in the banking environment are likely to be beneficial to elderly consumers. Elderly persons who tend to concentrate their savings in passbook savings accounts for ready access have suffered severely from being paid only 5 to 5½ percent on their accounts while the rate of inflation and the market interest rate on Certificates of Deposit were 10 to 15 percent. The Act requires that interest rate ceilings be phased out within six years, and the behavior of the Depository Institutions Deregulatory Council (created under the Act to supervise the interest rate phase-out) suggests that rate ceilings may effectively disappear before then.

The Issues

A. Cost to Consumers

The Act will increase the cost of doing business for financial institutions, and this cost will probably be passed on to consumers. For example, many banks now provide "free" checking accounts for elderly consumers, or for anyone who arranges to have government benefits paid by direct deposit. (Such accounts are not really free because the bank gets the use of the money without paying any interest on it). Banks will be less willing to provide such

"free" services when they pay a market interest rate on the funds in the account, as well as a fee to the Federal Reserve System for each check processed. In addition to increasing charges for certain services, financial institutions may discontinue some unprofitable services entirely. For example, they might stop making consumer loans below a certain amount because the cost of processing the loan exceeds the return from making it. Low-profit branches may be closed and replaced with automatic teller machines. The impact of these changes may be especially severe on the elderly, many of whom depend on personalized services at local banks to help them manage their money.

B. Higher Interest on Bonds

As another means of protecting elderly persons from inflation, consumer groups have pressured the government to increase the yield on U.S. Savings Bonds. The yield on Savings Bonds has recently been increased to 8 percent. A bill has also been introduced in Congress (H.R. 5709) to create "Inflation Fighter Bonds" issued by the government, which would pay to small savers aged 65 and over a rate of interest equal to the inflation rate plus 2 percent. Attention must be focused on the interaction of proposed Inflation Fighter Bonds with other types of financial instruments. Possible effects such as reductions in the rate of savings in private institutions require examination. Other alternatives to protect the elderly from inflation should be evaluated.

V. ALTERNATIVE MORTGAGE INSTRUMENTS

The Problem

Arising partly as a means of ensuring lenders a reasonable rate of return on investments, alternative mortgage instruments are becoming increasingly common. Some instruments, such as variable rate, renegotiable rate, or shared appreciation mortgages, are used primarily for new home financing. They are differentiated by the structure and permissible terms of the transaction, for example, the amount and frequency by which interest rates can fluctuate. In a variable rate instrument, the interest rate can fluctuate annually but the overall change in the interest rate permitted over the life of the mortgage is limited. In a renegotiable rate mortgage, the interest rate can increase or decrease only every three to five years by a certain amount for each year. Some renegotiable rate mortgages have a ceiling on the total change in the interest rate permitted over the life of the mortgage; others do not. In a shared appreciation mortgage, the buyer pays a lower rate of interest initially, but agrees to pay a certain percentage of the value of appreciation of the property at the time of sale. If the house is not sold after ten years, some lenders will then require payment on the appreciation.

Other instruments, such as reverse annuity mortgages, create income out of a homeowner's equity in his or her property. This instrument is particularly relevant to older persons who own their homes outright or have nearly paid off their mortgages. In many places, their homes have appreciated greatly in value. A reverse annuity mortgage enables such a person to sell this asset while retaining the right to remain in the home for some period of time. Under this type of instrument, a company buys a house from a homeowner, making monthly payments over a period of years. Unlike a conventional mortgage, however, the elderly person retains possession of the house while the buyer makes payments.

The Issues

A. Flexible Rate Instruments

Those elderly who wish to sell their homes to buy smaller houses or condominiums, or purchase homes in another area of the country, may be adversely affected by the trend toward flexible rate mortgages. The underlying assumption behind these instruments is that the borrower's income will increase over time. This is not the case

with older people who rely on relatively fixed incomes, and who may not be able to afford increased monthly payments caused by a rise in the interest rate. Financial institutions could be required to maintain a certain percentage of their mortgages as fixed rate loans to ensure the availability of mortgage credit to low and moderate income buyers, including many elderly. Such a commitment might be mandated by federal agencies or negotiated by consumer groups.

B. Reverse Annuity Mortgages

Reverse annuity mortgages can benefit the elderly if they are structured properly. These contracts can be designed to permit the homeowner to live in the house until the homeowner dies or agrees to sell his or her interest. On the other hand, if the term of a reverse annuity mortgage is limited to a fixed number of years, an elderly person could lose the right to remain in the house if he or she outlives the payment period. Another important consideration in this type of instrument is the language governing how the homeowner can pay back the amounts received and redeem the house. It is imperative that a homeowner fully understand the type of agreement he or she is making and its provisions before signing the mortgage papers. Currently, reverse annuities are neither common nor widely marketed. Benefits to the elderly might be substantial if this type of mortgage were more widely available.

Additional considerations for homeowners are the consequences of the reverse annuity on taxes, public assistance, and the person's estate. For instance, some public assistance programs might consider payments received under a reverse annuity as income, rather than the liquidation of an asset. Thus, some elderly who might qualify for public assistance if they retained their home could be ineligible for such assistance if they received payments under a reverse annuity. Homeowners should be aware of such consequences before agreeing to sell their home. If this is a widespread problem, local public assistance regulations should be studied to determine the impact of reverse annuities.

VI. SECURITY INTERESTS

The Problem

A large percentage of the elderly own their homes. In many instances this property may be old and in need of maintenance or repair. To perform these tasks the homeowners generally rely on credit, often pledging their homes as security. Even if a home is not pledged as security in a contract, liens or security interest in the home are often obtained solely through the operation of law. The elderly are frequently not aware of the ramifications of such security interests.

The Issues

A. Workman's Liens

In most states, through the operation of law, contractors, subcontractors, and materialmen are automatically granted a lien or security interest in any real property which they build or repair. In a number of states, these mechanic's or workman's liens have been expanded and now include improvements and repair, built-in appliances, and other non-easily removable items such as wall to wall carpeting. In addition to these statutory liens, two states, Illinois and Pennsylvania, still permit the use of "confession of judgment notes" which authorize a creditor to enter a judgment against a debtor without notice to the debtor, in the event the debtor should default in the payment of the debt.

Some home improvement contractors may take advantage of the elderly by performing work for them which is incomplete or unsatisfactory. Even though the homeowner may be contesting the quality of the work, the lien exists to cloud the title to the home, which may prevent the consumer from securing other needed credit, transferring the property to heirs, or selling the property. In addition, the elderly consumer

may not know of the statutory lien, and may fall into the trap of being forced to sell the home to satisfy the lien. There is a question of whether confession of judgment clauses should be permitted in consumer contracts. More needs to be known about the impact of these consumer credit problems on the elderly.

B. Unneeded Repairs

Pledging their home as security, elderly homeowners are sometimes coerced into purchasing major unneeded home improvements, such as a complete roof, when in fact the existing roof could be repaired by less expensive patching. Consumers need to know that when they pledge their home they are provided, under the Truth in Lending Act, with a three day right of rescission on the contract. Consumers also need to understand that if their contract is sold, and they have a claim against the contractor, they can often assert that same claim against the holder of the note.

VII. COORDINATION OF BILLING/PENSION CYCLES

The Problem

People on fixed incomes receive pension or retirement checks monthly. They also receive bills for charge accounts monthly. Often, however, the charge accounts fall due prior to the date of receipt of that month's pension check. Or, for example, if a charge account payment is due on the 5th of the month (and therefore has to be mailed several days prior to that), and a person receives his or her pension check on the 4th of the month, the charge account payment, although mailed immediately upon receipt of the pension check, is consistently late.

The Issues

A. Slow Pay Record

Although a pensioner may be extremely creditworthy, that is, willing and able to repay the debt, the problem created by the lack of coordination between billing dates and pension receipt dates often results in the person being assessed late payment charges and saddled with a "slow pay" record. This in turn adversely affects his or her credit rating. The extent of the problem needs to be ascertained and possible cycle coordination studied.

VIII. TV AND APPLIANCE RENTAL INDUSTRY

The Problem

The TV and appliance rental industry is one which affects the lives of elderly low income consumers. In this business, TV and home appliances are rented on a week to week basis by salesmen going door to door. Consumers are told that they can own the TV or appliance after making payments for a certain number of weeks.

The Issues

A. No Disclosure Required

If the rental contract used in this business is cancellable by the customer at any time, then it is not subject to the credit disclosure requirements of either the Truth in Lending or Consumer Leasing Acts. Therefore, consumers often are not told the total price they will be paying upon purchase, and often do not understand that the total price they will pay to purchase an item under the rental plan may exceed the price they would pay if they bought the item for cash or on credit. This problem needs to be brought to the attention of the elderly.

RECOMMENDATIONS

The following section contains the resolutions that were developed and adopted by work group delegates at the mini-conference.

Preamble

It is recognized that some of the recommendations below may involve at least initial costs to lenders. Although most would benefit all consumers, others would benefit primarily the elderly, and may, in effect, constitute a subsidy to the elderly. If so, the cost is a proper one as part of society's obligation to its elderly population. However, some of the apparent initial costs of recommended changes would, in the long run, enable lenders to make sounder credit decisions and offer credit to more people. This would benefit the credit providers by balancing off or exceeding the cost of making the recommended changes.

Resolution Topic: CONSUMER AND PROVIDER EDUCATION ON CREDIT

Statement of Recommendation: Be it resolved that:

1. Educational programs and materials should be prepared and distributed by business, government agencies, educational institutions, and consumer organizations to provide the following kinds of information to elderly consumers: (a) whether the use of credit is appropriate; (b) how to shop for credit; (c) credit rights, responsibilities, and remedies under federal, state, and local law; and (d) common qualifications for creditworthiness.
2. Special efforts should be made to develop creative means of communicating this information, including the use of electronic media, senior centers and organizations, and women's organizations.
3. Special consideration should be given to developing credit education programs for foreign language groups and the physically disabled elderly.
4. Educational programs of this nature should also be implemented throughout the educational system to alleviate potential credit problems of future generations of elderly citizens.
5. Programs should be developed to ensure that financial institutions, other creditors, and government entities concerned with consumer credit are made aware of the special needs and characteristics of elderly consumers.
6. With regard to public agencies which make policy decisions in the area of consumer credit, the participation of elderly consumers in the decision-making process should be encouraged.

Resolution Topic: THE ELDERLY'S ACCESS TO CREDIT

Statement of Recommendation: Be it resolved that:

1. Regulation B of the Equal Credit Opportunity Act should be amended to require creditors who deny credit because of insufficient credit histories to inform denied credit applicants of their rights to have applicable spousal credit histories considered.
2. Creditors should be required to give the same weight to other sources of income as is given to earned income. The same standards of reliability applied to earned income should also apply to other sources of income
3. Creditors who consider income should also be required to consider assets to determine creditworthiness. Creditors should be prohibited from giving negative weight to multiple income sources.

4. Lenders should facilitate the elderly's access to automatic teller machines (ATMs) and use larger type sizes.
5. Creditors should provide meaningful and specific reasons for denial of credit.
6. A study should be conducted to determine if the elderly have difficulty obtaining credit insurance or other credit-related insurance, and if this has increased the cost of credit for the elderly.

Resolution Topic: CREDIT RIGHTS AND RESPONSIBILITIES

Statement of Recommendation: Be it resolved that:

1. Credit contracts should not contain clauses that give unfair advantages to creditors.
2. The Federal Fair Debt Collection Practices Act should be amended to include collection practices of the original creditor and remove the exemption for attorneys from the Act.

Minority Opinion: Credit contracts should not contain clauses such as judgments by confession, waivers of exemption, wage assignments, blanket security interests, unrestricted assignment of attorneys fees, excessive late charges or extension fees, pledge of final paychecks, acceleration clauses, payment of collection fees, right to collect deficiency, waiver of right to privacy, cosigner guaranty, continuing cosigner guaranty, and insecurity clauses.

Resolution Topic: DISCLOSURE OF CREDIT INFORMATION

Statement of Recommendation: Be it resolved that:

1. All financial disclosures should meet the special requirements of the elderly in providing timely notification, in plain language, and in an appropriate type size or outreach medium.
2. Model credit forms and clauses for adoption by creditors should be developed.

Resolution Topic: FACILITATING ACCESS TO HOUSING CREDIT

Statement of Recommendation: Be it resolved that:

1. The elderly should have access to equity in their homes on equitable terms, including second mortgages at fair rates and cost.
2. Reverse annuity mortgages should be more broadly available in a form that allows the elderly to remain in their homes for the rest of their lives.
3. Pension funds should be encouraged to invest in fixed rate mortgages for middle to low income elderly debtors.
4. State home repair programs which contemplate repayment upon transfer of property or settlement of an estate should be expanded.
5. Financing should be available to the elderly to buy new homes, mobile homes, etc., through the use of appropriately structured shared appreciation mortgages.

Resolution Topic: FINANCIAL INSTITUTION RELATIONSHIP AND PROCEDURES

Statement of Recommendation: Be it resolved that:

1. Financial institutions should take care to facilitate the establishment of new or different relationships with elderly consumers.
2. The elderly should have reasonable and free choice in their relationships with financial institutions, particularly in regard to the use of electronic funds transfer (EFT) versus paper-based payment systems.
3. Creditors should be sensitive to the unique social needs of the elderly and provide alternative services at fair cost.
4. Educational efforts should be expanded to apprise the elderly regarding the use of new or changing financial products, services, and technologies such as EFT, direct deposit, NOW accounts, variable rate mortgages, etc.
5. Creditors should be sensitive in the pricing of financial services, recognizing that many elderly consumers are small savers. Charges to elderly consumers with small savings should be minimized.

FOOD

INTRODUCTION

The most recent U.S. Department of Agriculture study (June 1979) on the food expenditures of the elderly shows that those over 65 spent an average of about 22 percent of their before-tax income on food, compared with about 17 percent for those under 65. For older Americans below the poverty line, the percentage of income spent on food can reach as high as 40 percent.

The issues examined in this paper focus on food-associated problems of particular concern and interest to elderly consumers. They include:

- food price inflation
- food advertising
- food information
- consumer nutrition information
- access to food
- layout and services in the store
- eating out

I. FOOD PRICE INFLATION

The Problem

The average annual food inflation rate has been approximately 15 percent during the past several years. If food inflation continues, so will the food-buying dilemma. Older people living on very tight budgets will face housing and medical costs, which *must* be paid, possibly leaving insufficient funds to satisfy even minimal food requirements. A recent survey found a significant portion of the elderly cutting back on food purchases as a means of coping with rising costs.

The Issues

A. Need for Nutritious Foods

Many foods older adults need most also cost the most. The prices of fresh fruits, and vegetables, fruit juices, and dairy products are rising rapidly. Meat, a favorite American staple, is probably the highest priced item, and the USDA forecasts significant cost increases in 1981.

The low-income elderly face a particularly difficult task when they attempt to purchase the most nutritious foods for the least cost. The food items listed on the USDA's Thrifty Food Plan, a nutritious menu-planning device for low-income persons, increased by 11.8 percent from September 1979 to September 1980, while the food comparisons of the Consumer Price Index rose by 10.3 percent during the same period. Meanwhile, costs for bakery and cereal products, fruits and prepared foods all rose by 11 percent.

B. Meal Planning

Shrinking food budgets force older adults to think about buying only what they need. Wasted food not only costs more, it creates storage problems that can contribute to spoilage and possible illness from eating unsafe leftovers. In order to think "small," older adults need to plan menus, recipes, and storage space—and balance those concerns against buying in bulk, which may be cheaper. Supermarkets also might be encouraged to think "small" by offering single-serving portions of meat, poultry or other food items.

C. Federal Assistance Programs

There are several federal programs designed to help primarily low-income persons, including the elderly, stretch their food budgets. These programs are greatly under-utilized. A recent USDA Food and Nutrition Service study indicated that 40 percent of those eligible but not participating in public food assistance programs were over 65.

The largest program, food stamps, is not geared specifically to the elderly. Although eligibility procedure exceptions are made for older adults, the food stamp program does not address the food access problems and the "welfare stigma" that par-

ticularly plague the elderly.

The Nutrition Program for the Elderly, which offers meals and social services at community sites, reached only about 10.5 percent of eligible recipients in fiscal year 1978. While this program is available to older people of all income groups, limited funding has hampered participation. Home delivered meals progams, which deliver food to homebound elderly, are serving no more than 100,000 people.

II. FOOD ADVERTISING

The Problem

The eating habits and nutrient intakes of the elderly, indeed of all consumers, are affected by many environmental factors. One important factor is use of and exposure to the media. It has been reported that elderly persons tend to watch television more than any other age group. Consequently, they are exposed to its advertising more than any other age group. Some research, albeit very limited, has examined the relationship between the television viewing habits of consumers sixty years and older and their food consumption habits. The research built upon previous studies which had shown that greater social interaction—another environmental factor—tended to improve the quality of the elderly's diet because it diminished solitary eating, a practice which can discourage adequate food intake.

This more current research reported, not surprisingly, that "snacking" was quite positively related to the amount of television watched. It also appeared that, in some elderly consumers' diets, snack foods were replacing other, more nutritious foods.

Given the volume of food advertising to which the public as a whole is exposed, and the fact that elderly consumers appear to be exposed at least as much as, if not more than, other groups to the various media which carry these advertisements, it is reasonable to believe that food advertising is influencing to some significant degree the food purchasing decisions of the elderly.

The Issues

A. Advertising Trends

Approximately $1.6 billion is spent annually on food advertising. In general, processed foods tend to be more heavily advertised than traditional foods. For example, in 1978, the ten most heavily advertised products included three soft drinks (ranked 1, 2, 4); two chewing gums (3, 10); Shake 'N Bake Mixes (5); Folgers Flaked Coffee (6); Pringles Potato Chips (7); Jello Gelatin Dessert (8); and Florida Citrus Juices (9). Only Florida Citrus Juices could be characterized as a food in its totally natural form. Many of the other top product categories are very highly processed. Furthermore, the disparity in advertising expenditures is dramatic in some cases. For example, a combined total of $75,676,200 was spent on Coke, Pepsi and 7-Up advertising whereas $12,112,800 was spent on advertising of all forms of Florida Citrus Juices.

This is not to suggest that any of the heavily advertised foods are necessarily bad when eaten in appropriate amounts as part of a balanced diet. It does suggest, however, that the consumer is much more heavily exposed to advertising for processed foods and that one general effect of food advertising would be to encourage a shift in purchasing patterns toward a greater percentage of processed foods. In general, these foods tend to be higher in fat, sodium and sugar than others, and their consumption in large amounts makes it more difficult to control intake of these potentially harmful substances.

B. Nutrition Claims

In the late 1960's and early 1970's, perhaps in response to a raised consciousness among consumers regarding nutrition created in part by the White House Conference on Food, Nutrition and Health, more nutrition claims started to appear in food advertisements. This usually occurred in a highly promotional context and often

resulted in overstatement of the nutritional value of the advertised foods. At first, a major focus of these claims appeared to be the vitamin and mineral content of various foods with an emphasis on how foods were enriched or fortified. There was also a series of "nutrient fads" during this time and food advertising responded to assure consumers that there were, for example, abundant supplies of protein or Vitamin C in their foods and, in some cases, to tout the benefits of consuming large amounts of those nutrients. As the 1970's progressed and the focus of nutrition and related health sciences increasingly shifted from nutrients and problems of nutrient deficiency to problems caused by overconsumption and particularly the diet-related aspects of cardiovascular disease, food advertising expenditures have gone into advertising for oils and margarines and for other products which have been developed as substitutes for traditional foods high in saturated fat or cholesterol. For example, entire product lines of substitute breakfast meats and egg substitutes have sprung up and have been heavily promoted as responsive to the need to cut down on traditional foods which are high in fat and cholesterol.

C. Diet and Health Foods

It can be expected that the tendency to develop new products to respond to diet-health concerns will continue and will be accompanied by heavy advertising to bring the products and their alleged benefits to the attention of all consumers. Although the tendency of industry to respond to diet-health concerns by product innovation is in itself of potentially great benefit, there are two aspects of this trend that will bear close watching in the near future:

- The promotion of health benefits frequently tends to be overstated and inadequate to disclose the controversial nature of the evidence relating certain substances in the diet to either health risk or health benefits. Although evidence is substantial in many areas, there are few such causal links that have been established by scientific evidence satisfactory to most experts in the area. In addition, food advertising tends to feature single products and often major dietary modifications going well beyond the substitution of one food for another are necessary in order to obtain any benefit. Unless the advertiser is careful to make these modifications clear, a consumer can be misled to his or her detriment either by overestimating the benefit to be obtained or by failing to consider additional dietary changes or behavioral modifications which may be necessary to obtain any benefit.
- Dietary manipulations and particularly the inclusion of new, processed foods as substitutes for traditional foods can present unforeseen risks. New goods may contain totally unexpected ingredients which a consumer may not want to eat but may not realize are contained in these foods. Therefore, additional information is necessary about these ingredients and, in some circumstances, about the health risks or controversies about health risks associated with them.

III. FOOD INFORMATION

The Problem

An Administration on Aging-funded study by the University of Pittsburgh found that "the elderly generally utilize fewer information sources because of a decreasing number of social contacts, physical immobility, and the decreased availability of information for the elderly."

The food marketplace, for those who can get to it, does offer several information tools that can be used to make informed food choices. Yet some of these tools are in jeopardy. Older adults have a particular stake in the maintenance of these information channels and in the way they are presented and altered.

The Issues

A. Item Pricing

Item pricing, a consumer right recognized by shoppers in every age group, is critical for the older adult. This issue is of particular importance today because item pricing is in danger of being eliminated in many supermarkets by the advent of the computer-assisted checkout system.

Specifically, the benefits of item pricing are that it:

- presents price information in a clear and useable format.
- provides an instrument for comparison shopping and price awareness.
- provides a defense against instantaneous price changes.
- verifies that the shelf tags are accurate and correspond to the product.
- verifies the accuracy of the price consumers pay.

A 1976 Michigan State University study on consumer behavior concluded that shoppers in stores without conventional item pricing were at a significant disadvantage. Further, while the elimination of item pricing provides an opportunity for supermarkets to reduce their costs, particularly for labor, there is no guarantee that such savings would be passed on to consumers.

In order to safeguard consumers against the elimination of visible item pricing, several states have passed laws and regulations to require price marking. These states include Connecticut, Michigan, Minnesota, New York, Rhode Island and Massachusetts. Many local ordinances also have been adopted, and other states are now considering such bills.

B. Food Labeling

In today's complex and expensive food marketplace, food labeling is an essential vehicle for transmitting vital health and dietary information to elderly consumers. Needed is a refocused food label that is easy to understand and use, and provides necessary information on specific foods to help consumers link their diet to good health.

In 1978 the Food Labeling Task Force of the FDA, USDA and FTC, as a first step toward development of a comprehensive food labeling policy, held public hearings across the country and received more than 9,000 written comments on the many aspects of food labeling. The record demonstrated great consumer interest in labeling changes, including:

- mandatory nutrition information
- percentage ingredient labeling
- protein, fat, sodium and cholesterol declarations
- open dating

Although the FDA and USDA published their proposals in the Federal Register in 1979, no further regulatory action has been initiated. Congressional hearings also have been held on new food labeling bills during the previous session, but no committee action was ever taken.

Currently, nutrition labeling is voluntary, while ingredient disclosure is mandatory except for foods with a standard of identity. Some local jurisdictions have adopted specific labeling regulations such as open dating. However, a consistent, uniform policy is lacking.

Several concerns remain to be addressed. Most importantly, nutrition information on the label is critical in preventing disease and promoting good health because diet is a risk factor in six of the ten leading causes of death. For example, hypertension is prevalent among the elderly, and salt-restricted, fat-modified diets are commonly recommended. The nutrition label is usually the older person's *only* source of diet-related information at the point of purchase.

Of additional concern to the elderly is the size of print and the label format so that it can be readily used. Finally, the refocusing of current food labeling efforts, including shelf labeling and the development of a comprehensive legal framework

for food labeling, also deserves attention from appropriate regulatory agencies.

C. *Comparison Shopping*

The age-old consumer rule to compare prices and brands before buying is still valid in today's supermarket. Comparison shopping, with the aid of unit pricing, is the most effective way to get the best buy on a desired food item. The elderly need education and encouragement in this area, however. A Colorado State University report shows that older adults continue to prefer brands they have always purchased and are unwilling to try generic brands, despite cost savings. House brands offer another, cheaper alternative that the elderly often ignore. Brand "loyalty" can prove to be an expensive habit.

IV. CONSUMER/NUTRITION EDUCATION

The Problem

During the past decade scientists have found increasing linkages between diet and disease, including many of the major ailments that afflict the elderly: hypertension, obesity, coronary disease, and, possibly, diabetes and cancer. At the same time, growing technology and society's demand for convenience has led to an increase in processed food items. These foods often contain fat, salt and sugar levels that exceed the moderate amount scientists recommend to avoid diet-related diseases.

To communicate this information to all Americans, in 1980 the USDA and the Department of Health and Human Services published seven dietary guidelines for Americans that offer scientifically-based counsel on healthy eating habits. Each of the seven guidelines has special implications for the elderly; four relate specifically to the fat and cholesterol, starch and fiber, sugar and sodium that scientists say we should regulate in our diets.

The Issues

A. *Special Diet Information*

Common disease-related diets for older adults include: fat-modified, sodium-restricted and diabetic. Following these special diets requires that the elderly know what foods comprise each diet and be able to shop carefully, using nutrition labeling. Current nutrition labeling, unfortunately, does not offer adequate shopping assistance to older adults on special diets, for several reasons:

- The elderly and other groups are often unsure about the names of basic nutrients. For example, some people do not equate salt and sodium.
- Nutrition information on labels is voluntary. Not all foods desired by older adults carry labels. Further, the nutrition information panel does not have to address all the nutrient issues of concern to elderly consumers. This is a case where omission can be misleading.
- The ingredient list is often confusing. Sodium, for example, can appear as a component of another ingredient such as monosodium glutamate. Consumers may be unaware of this possibility and miss critical information altogether.

B. *Food and Drug Interaction*

Many elderly on special diets may also be involved in some kind of drug therapy. For example, antacids, which are taken by many older adults, interact with sodium. Information on possible food and drug interactions may need to be made available at the point of food purchasing.

C. *Convenience Foods*

The thousands of convenience foods currently in the marketplace offer quick and easy meals for elderly consumers, but in most cases are not the cheapest alternative. Nutritionally speaking, they are almost always higher in salt and fat than processed food items. Unless the item is labeled clearly, consumers may not be aware of this higher fat and salt content. All consumers should know how to evaluate the convenience of a TV dinner, for ex-

ample, considering cost and nutritional factors.

V. ACCESS TO FOOD

The Problem

In 1967 there were approximately 185,000 grocery firms representing about 300 chains (11 or more stores) in U.S. inner-city areas. By 1975 the number of stores had dropped 17 percent to 155,000. The number of stores in Boston, Washington, D.C., and Chicago, for example, has declined between 28 and 50 percent during the past ten years. This urban scenario, while particularly bleak, is being played out in rural and suburban communities as well. The exodus of supermarkets means food is less accessible than in the recent past, and decreased access means increased problems for elderly consumers who are often less mobile than younger adults and live in communities where food retailers are least accessible.

The Issues

A. Alternative Foodmarketing

Alternatives to traditional food marketing offer general or partial solutions. Across the country, there is a small but growing pattern of innovative marketing methods, including:

- food co-ops
- farmers' markets
- independently or community-operated supermarkets

At the same time, there is growing interest in marketing solutions that promote self-sufficiency, such as food banks, box stores, gardening, and a variety of cooperative efforts. Unfortunately, most of these growing marketing alternatives do not address the special physical and geographical needs of older Americans. Solutions tailored to the specific needs of older consumers, such as bulk-buying through congregate programs and mutual-help joint shopping, should be explored.

B. Transportation

Transportation to food stores is not a problem unique to the elderly, but more of them do have difficulty with it. Many social service institutions and organizations, government-funded programs, residences catering to the elderly, and supermarkets themselves have forged efforts to provide regular bus, car or van transportation for older adults. Some of these services are jeopardized by rising gas costs and general inflation. More and varied efforts are needed in this area.

C. Special programs

Some nutrition programs for the elderly have increased participation through such innovative efforts as:

- bring-your-own bag lunches on certain days to increase the number of older people eating together;
- buy-your-lunch components alongside a program-mandated meal service;
- evening and weekend congregate eating arrangements such as pot-luck (covered dish) dinners and group eating in private homes.

Innovative service-expanding activities need to be encouraged through broad interpretation, and perhaps re-writing of program regulations. Community cooperation can also help expand the scope of these services as well as the number reached.

VI. LAYOUT AND SERVICES IN THE STORE

The Problem

Some older adults face a variety of shopping obstacles in grocery stores, particularly large supermarkets. These obstacles, combined with their demonstrated loyalty to particular stores, brands of food and shopping habits, make food shopping for many elderly a more difficult task than it should be.

A recent Colorado State University study, sponsored by the NRTA-AARP Andrus Foundation, presents a comprehensive picture of the shopping dilemma facing older adults. The study documents 20 problem areas related to layout and ser-

vices within the grocery store, along with proposed solutions for addressing those problems. Some of these areas are highlighted below:

The Issues

A. Physical Layout of Stores

The physical layout of the store often presents problems, including:

- shelving height
- cluttered aisles that make it difficult to maneuver bulky shopping carts
- item location or relocation
- display changes
- crowded conditions

B. Food Packaging

The way food is packaged represents another area of difficulty. Some elderly consumers have a hard time with heavy bottled products, canned goods and stiff cardboard packages such as milk cartons. They prefer bags for frozen foods, for example, and the smallest can size to avoid storage and possible spoilage. While they prefer well-known brands, they also look for legible price marks on each item, and packages they can open and reclose easily.

C. Special Services

Checkout is a special problem area as well. Some older Americans can't stand in a checkout line for a long time. At the same time, they are troubled by fast checkouts where they have difficulty keeping up with the price tabulation. Checkers could be helpful by being aware of vision or hearing problems of the elderly as well as being sensitive to their special needs.

Store policy could also address these problems. One store in the midwest, for example, designated an hour at the end of the day for older-adults-only shopping.

In addition to help from checkers, the elderly could benefit from general in-store service. A helpful, responsive attitude by other store personnel, from stockpersons and butchers to managers, could help older adults with problems like item location, reading prices, carrying groceries, and other concerns.

The lack of accessible rest areas or restrooms is a special problem for some elderly.

VII. EATING OUT

The Problem

The American family now spends 33¢ of every food dollar in a restaurant, and one of every four eateries is a fast food restaurant. Statistics show that the elderly eat out less than their younger counterparts, but restaurants are still an important part of the social, economic and nutritional lives of older Americans.

The Issues

A. Nutrition Information

Nutrition information is hard to obtain in a majority of restaurants, where food can be high in fat, salt and sugar—ingredients older adults should try to avoid over-eating. Currently, restaurants are not required to deliver nutrition information per se on their menus. Some fast food chains have developed nutrition information posters that identify ingredients and nutrient content in typical meals. These voluntary programs are being encouraged by the federal governent. But in most restaurants the individual must already know the probable ingredients of a dish and ask questions about it, then make a decision about ordering it.

B. "Truth-in-Menus"

A "truth-in-menu" movement has begun taking hold in various states around the country. Some state legislatures, and some city ordinances, enforce laws that require restauranteurs to be truthful about the food they list on their menu, prepare, and serve to patrons. For example, a restaurant listing "fresh" fish on its menu would be in violation if that fish were actually frozen; "imported" has to be imported; "homemade," homemade. Older consumers who are particular about their food tastes and traditions, as well as their nutritional in-

take, would benefit from wider application of such "truth-in-menu" efforts.

C. Costs

Perhaps the greatest deterrent to eating out for older adults is cost. Inflation has hit the restaurant industry with higher energy, labor and wholesale food prices. Higher meal prices are the result. Menu fraud when restaurants substitute less costly food products for those described on the menu actually accounts for three to five percent of the consumer restaurant tab, according to Los Angeles County officials investigating truth-in-menu violations.

Since most older Americans on fixed incomes must be careful about how often they eat out, their opportunities for important social and recreational interaction are reduced. Some restaurants have tried to encourage patronage by older customers by offering them reduced prices on meals during slow business hours.

RECOMMENDATIONS

The following section contains the resolutions that were developed and adopted by work group delegates at the mini-conference.

Resolution Topic: FOOD PRICES AND AVAILABILITY

Statement of Recommendation: Be it resolved that:

1. The limited incomes of some elderly should be supplemented through such programs as food stamps, meals on wheels, congregate meals, buying clubs, and food banks to provide for adequate nutrition.
2. A "Golden Food Card" should be issued to provide a supplementary resource for food purchases while preserving the older person's dignity and respect, since many older Americans are reluctant to make use of current publicly-funded food support programs.
3. Employment, either private or public service, should be available to all who want to work to supplement their income for food purchases and continue their contribution to their community.
4. Greater access to food buying should be provided through extended hours for social agencies and accessibility through special and supplemental transportation or food delivery.
5. National policies must assure the production of an abundant and stable supply of food so that older persons can be assured of the availability of food at affordable prices.
6. Food stamps should be accepted at restaurants and congregate meal centers.
7. Families which help support or maintain older family members within their homes should have access to support services.
8. Minimum housing standards should mandate facilities for safe food preparation including heat, refrigeration, and pure water.

Resolution Topic: ALTERNATIVE APPROACHES TO FOOD PURCHASING

Statement of Recommendation: Be it resolved that:

1. Given the trend toward relocation of stores in possibly inaccessible surburban areas, communities (including business, government and older Americans themselves) should encourage the development and use of alternatives to traditional food distribution systems. These alternatives include, but should not be limited to, the following: (a)

transportation to food sources; (b) food cooperatives and buying clubs; (c) community gardens, solar energy gardens and hydroponic gardens; (d) food banks and gleaner programs; (e) delivery of food to shut-ins and senior groups; and (f) support for development of localized discount food stores, such as warehouse stores, and day-old or "thrift stores."

2. The development of each alternative will require the coordinated efforts of business (for the development of new marketing concepts); government (for tax incentives and removal of regulatory impediments); and older Americans themselves (to recognize that their resources—time and experience—can be a motivating force to make these alternatives a reality).

Resolution Topic: CONSUMER EDUCATION

Statement of Recommendation: Be it resolved that:

1. Given the limited food budgets and special nutritional needs of the elderly, training on the benefits of nutrition should be provided to health care professionals, families, and others who work with the elderly. Existing nutritional education resources should be made available for consumer education programs to meet the special needs of older Americans.
2. Nutritional counseling should be made a reimbursable expense and individual and group counseling should be provided to assist older people with specialized diet problems. An interagency network should be established to develop methods of dealing with this nutritional problem. Emphasis should be placed on preventive programs dealing with nutrition, using existing communications channels. New partnerships should be established between the research and educational communities to accelerate and facilitate effective application of relevant research findings.
3. The presentation of price and nutritional information should be given a high priority. Good buying skills may be encouraged through: clear and accurate advertising and labeling; price information that is displayed conspicuously and in a form that is understandable as to content and size and which accommodates the special needs of the elderly, including the visually handicapped; attention to item pricing as a basic consumer right; and support for truth in restaurant menus. There should also be clear disclosure of the net quantity of products on packages and truthful, simple information about nutrient values, additives, etc.
4. A model teaching kit for older Americans should be developed to incorporate, but not be limited to, such tools as the following: unit pricing, label interpretation, reading dates, net weight knowledge, substitution of comparable products, brand name versus store name versus generic, coupon and rebate use, comparison shopping through the mails and the understanding of marketing strategies employed by the food industry.

Resolution Topic: NEED FOR FOOD AND NUTRITION RESEARCH, DEVELOPMENT, AND SURVEILLANCE OF HEALTH AND DISEASE PROBLEMS OF OLDER AMERICANS

Statement of Recommendation: Be it resolved that:

Although much is known, gaps exist in our knowledge of the diet and health problems of the elderly. Key areas requiring additional research include: further defining the relationship between diet and degenerative chronic diseases; defining specific nutrient needs for older individuals particularly in the presence of decreased caloric intakes; developing an improved understanding of the dietary patterns and nutritional status of both well and

chronically ill older individuals; and developing an understanding of the interaction between foods, nutrients and diets on one hand, and drugs, environmental contaminants and food additives on the other.

Food and nutrition research, development and surveillance concerned with maintaining health and reducing disease problems of older Americans must be sustained and augmented at all levels of the scientific community. Local, state and federal governments, as well as the private sector, should increase recognition and support for: the grant, contract and in-house research efforts of agencies such as the National Institutes of Health, Food and Drug Administration, and the U.S. Department of Agriculture (see the December 1980 Report on Human Nutrition and Research and Training by the Office of Science and Technology Policy); similar research supported by the private sector, individual industries and private foundations; efforts at state-supported universities with medical and allied science schools and food and agricultural research capabilities; implementation of the national nutrition status monitoring system recently submitted to the Congress.

Resolution Topic: NUTRITIONAL QUALITY OF FOOD PRODUCTS AVAILABLE TO OLDER PERSONS

Statement of Recommendation: Be it resolved that:

1. The entire food industry should emphasize nutrition in product research and development, and focus much greater attention on the marketing and advertising of particularly nutritious food products.
2. Specific nutritional needs of older Americans should be given increased attention in government feeding and information programs.

Resolution Topic: SOCIAL AND EMOTIONAL ASPECTS OF EATING WITH RESPECT TO PHYSICAL HEALTH

Statement of Recommendation: Be it resolved that:

1. The children and friends of older consumers need to be educated about the importance of the social aspects of eating. They should be aware that eating alone may contribute to deficiencies in diet through a loss of interest in preparing a variety of foods and poor preparation or serving techniques. They should be taught that the social amenities that accompany the meal (i.e., eating at a set time and washing up) contribute to a person's health.
2. Older persons should be encouraged to develop neighborhood meal exchange activities and dining together.
3. Agencies dealing with the health (psychological as well as physical) of the elderly should be made aware of the importance of including social interactions in all aspects of programs dealing with the elderly—congregate meals, meals on wheels, meal cooperatives, nursing homes, and senior citizen congregate housing.
4. Consumer representatives in the food industry should use advertising which shows dining together. Restaurants and other food providers should encourage group dining. Packaging should be designed to facilitate convenient group food preparation.
5. Additional research should be undertaken in this area.

INSURANCE

INTRODUCTION*

There are four kinds of personal insurance policies with which most people have direct experience during their lifetimes:

- auto insurance
- life insurance
- health insurance
- fire or homeowners insurance

In some respects older and younger Americans face different problems with personal insurance policies.

- Less frequent use of automobiles coupled with more cautious driving habits mean lower auto rates for those 65 and over.
- The need for life insurance protection diminishes with age, but retirement income needs may continue to make the elderly customers of life insurance companies.
- Medicare's gaps leave the elderly uncertain about the extent of their health insurance coverage.

Special problems and issues associated with three of the four types of personal insurance that particularly affect the elderly are examined in the following sections of this paper.

I. AUTO INSURANCE

The Problem

During the past decade, auto insurance companies have reversed their view of drivers 65 and over. Previously, older drivers were often rated up, refused coverage or refused renewal of previous coverage. Now it is clear that those age 65 and over can be expected to have a better claims experience than drivers aged 30 to 64. The elderly do not have fewer accidents, but the accidents that do happen are less serious and therefore less costly. It also appears that Comprehensive Coverage, which protects the owner of a car against theft, fire, vandalism and glass breakage, receives far fewer claims from the elderly. This may be due to the greater likelihood of elderly drivers being able to keep their cars in garages. Especially in cities, it seems that older persons would rather not have a car than to have to cope with the difficulty and dangers of on-street parking.

The Massachusetts Association of Older Americans was instrumental in the passage of state legislation in 1978 mandating a 25 percent discount on auto insurance for drivers 65 and over, but statistics indicate that an even larger discount would be justifiable.

The Issue

A. Auto Insurance Rates

In most states auto insurance rates are set by competition among insurers, and, the state insurance commissioner may have the power to disapprove rate filings. Auto insurance might be enough of a burden for the elderly to warrant organizations in other states besides Massachusetts intervening in the rate filing process. More research is needed to determine whether competition among auto insurance companies is sufficient to assure that rates will be commensurate with claims experience.

II. HEALTH INSURANCE

The Problem

The most troublesome form of insurance facing the elderly is health insurance, despite the fact that the United States has a health insurance program designed to serve the elderly—Medicare.

The enactment of Medicare involved a compromise that left gaps for private health insurance to fill. The sale of Medi-

*At the request of the work group participants this paper has been slightly revised from the original version circulated prior to the conference.

care supplement policies has become a big business in which salesmen and the companies they represent are free to operate with little oversight or regulation. As a result, many elderly persons have been sold far more supplementary coverage than they need, and many policies offer extremely poor value for their cost. It is common for persons age 65 and over to have three or four health insurance policies. In testimony before the Senate Subcommittee on Aging, a man told of his 67-year-old mother who had been sold 17 policies by the same company. She was spending 68 percent of her income to pay for supplementary health insurance.

In a 1978 report entitled *Private Health Insurance to Supplement Medicare*, the Federal Trade Commission staff identified the following specific problems:

- Policies are sold that contain overlapping and duplicate benefits.
- Policy forms are not standardized (as they are in auto and homeowners insurance) making it difficult for consumers to shop for lower prices.
- Virtually no insurer offers coverage for prescription drugs.
- Doctors are free to reject Medicare fees and charge what they wish; no insurer can guarantee to pay a doctor's fee, no matter how high.
- Confusion exists among the elderly about coverage of nursing homes. Coverage is usually restricted to short stays in skilled nursing facilities after hospitalization.
- Agents replace older policies with new ones so they can earn higher first year commissions. Restrictions on coverage of pre-existing conditions may be reimposed.
- Hospital indemnity policies (benefits of $X per day in the hospital) that most companies like to sell bear no understandable relationship to the gaps in Medicare.
- Many companies' policies have low loss ratios; pay-outs are low in relation to premiums charged.

The Issues

A. Medicare Gaps: Excess Physician Charges

The FTC noted that only 38 percent of the health care expenses of the elderly are covered by Medicare. Unfortunately, the FTC's statistic has been seized upon by the health insurance industry to oversell its policies. In fact, Medicare pays more than 70 percent of the hospital bills of Americans 65 and over. The 38 percent figure includes Medicaid payments and many health care expenses that no one would expect Medicare to cover.

The gap in Medicare that no insurer fills precisely is excess physician charges. Recently, a Washington-based public interest research group, Public Citizen, released a study on physician reimbursement under Medicare. Some of the findings include:

- Due to the $60 Medicare deductible, the 20 percent coinsurance payments, non-covered services, and charges in excess of Medicare norms, only 30 percent of doctor bills for the elderly are being paid by Medicare.
- The percentage of bills for which a physician accepts assignment under Medicare (acceptance of Medicare-set fees as full payment) has dropped from 61.5 percent in 1969 to 50.6 percent in 1978.
- Excess charges in 1979 were $1.1 billion. The average excess charge per Medicare enrollee per year was $43 in 1979, up from $3 in 1968.
- Excess charges now amount to 10 percent of total physician billings to the elderly, up from 2 percent in 1968.
- Out-of-pocket costs ($60 deductible, 20 percent coinsurance, and possible excess charges) for a hysterectomy in the Washington, D.C., area in 1979 ranged from a low of $168 (no excess charge) to a high of $918.

The study's authors found that the impact on the elderly is not only financial. Many elderly persons may refrain from

seeking timely care due to fears of extreme excess charges. Among their recommendations were the following:

- The Health Care Financial Administration (HCFA) should send a semi-annual warning and explanation to Medicare enrollees about excess charges. Medicare Request for Payment forms should also contain a warning.
- Lists of physicians who accept assignment and those who don't should be published in each area.
- Organizations that work on behalf of the elderly should fight excess charges. If HCFA won't publish lists of physicians accepting assignment, perhaps senior organizations should.

B. Cancer Insurance

The most controversial form of health insurance sold to the elderly is cancer insurance. A major study by the House Committee on Aging, headed by Rep. Claude Pepper, charged that much of the cancer insurance sold is a "rip-off" in which policyholders get back less than 40¢ in benefits for $1 paid in premiums. Other criticisms leveled at cancer insurance were:

- Scare tactics are used to sell policies. Advertising and sales talks appeal unduly to fear by the elderly of this "dread disease," the insurance industry name for this type of coverage.
- The purchase of cancer insurance tends to leave buyers uncovered for other serious illnesses whose incidence is far more likely. Buying cancer insurance, it has been said, is like buying insurance for the right front fender of a car.
- Claim payments in cases of prolonged cancer treatment tend to cover less of the hospital and medical bills than is implied by the advertising.
- Advertising tends to imply that costs for treating cancer are larger than is typically the case.
- Most life insurance companies that sell health insurance will not issue cancer insurance policies, for the reasons mentioned above. Consequently, the market loses competitive pressure from these companies.

Arguments in favor of cancer insurance are:

- It is not costly.
- It is sold purely as a supplement to other health insurance.
- It provides reasonably large benefits for serious illnesses.
- It should be available in a free market economy to those who wish to buy it.

Nevertheless, five states, Connecticut, Massachusetts, New Jersey, New York and New Hampshire, have banned the sale of cancer insurance policies.

C. Regulation

The business of insurance in the United States has always been regulated by the states, despite a 1944 U.S. Supreme Court decision holding insurance to be an interstate commerce business and therefore subject to federal control. This decision was soon followed by passage of the McCarran-Ferguson Act that restored regulation to the states subject to the right of Congress to assert federal regulatory authority in one or more areas at any time.

The advantages of state regulation are diversity of approach and regulation closer to home. Disadvantages include inconsistency of regulation, inadequacy of staff, especially in technical areas, and the greater ease with which the industry can secure its goals by lobbying.

A recent report of the General Accounting Office called attention to the weaknesses of state regulation, and was soon followed by a Federal Trade Commission report critical of the life insurance business. Industry lobbyists were successful in getting Congress to pass a law removing the FTC's limited right to investigate and report on the insurance business. While the law did preserve FTC

authority to work on the sale of Medicare supplements, the current political situation has halted FTC involvement with insurance. Currently, the House or Senate Commerce Committees must instruct the FTC to carry out an investigation of the insurance business before it can begin its work.

The response of the states to the problems outlined here has varied considerably. The most far-reaching initiative, in Massachusetts, banned cancer insurance and set rigid standards for the sale of policies that are labeled Medicare Supplements, Medigap, etc. Any company wishing to sell such a policy must offer one or more of three packages of coverages and may not add to or subtract from the benefits in each package. Standardizing the coverage in each package makes it much easier to compare prices among companies.

The Massachusetts regulation allows the sale of other types of policies if they are not referred to as Medicare Supplements, but a minimum loss ratio of 65 percent is required for all policies sold to the elderly to assure good value. No other state has gone as far as Massachusetts, and only a few states have set minimum standards for policy benefits or loss ratios. Most have done nothing. No state has tried to deal with the problem of "stacking," the laying on of multiple policies whose total benefits far exceed any reasonable measure of need. Legislation requiring agents to determine the *suitability* of the policies they sell may be needed, but nothing like this has ever been tried. The only recourse state insurance commissioners now have is to proceed against individual agents under the states' unfair trade practice laws.

A new federal law should help prod t. states to take action regarding the sale of Medicare supplements. In June of 1980, Congress enacted P.L. 96-265 (the "Baucus Amendment") entitled, "Voluntary Certification of Medicare Supplemental Health Insurance Policies." This law is an amendment to Title XVIII of the Social Security Act, and is intended to work in the following way:

- The Secretary of Health and Human Services (HHS) must establish a procedure whereby Medicare supplement policies can be certified as meeting certain standards.
- The standards for what must be covered under qualifying policies are those set by the National Association of Insurance Commissioners. States, however, may set higher standards.
- Minimum "loss ratios" must be enforced: 60 percent for individual policies and 75 percent for group policies. These standards are intended to assure reasonable prices for Medicare supplements.
- Any insurer wishing to do so submits its policy for certification. It then may use an emblem to denote conformance to the standards. This has been called the "Good Housekeeping Seal of Approval" provision.
- States may seek HHS approval for their own voluntary certification programs if they meet or exceed federal standards.
- The final regulations implementing the Act were due March 1, 1981, but emblems may not be used until July 1, 1982.

There are shortcomings in the Baucus Amendment:

- The voluntary nature of the program means that its success depends on the extent to which older persons understand the program and come to rely on it.
- Insurers may continue to sell low-valued hospital indemnity and cancer insurance policies.
- The law contains no sanctions against the sale of duplicative or overlapping coverage.
- The NAIC coverage standards fail to include:

(i) an outpatient prescription drug benefit;
(ii) coverage of out-of-country medical services, for which Medicare pays nothing;
(iii) copayments required by Medicare for days 21 to 100 in a skilled nursing facility;
(iv) coverage of the Part A deductible, which is $204 in 1981;
(v) coverage of the Part B deductible or coinsurance until the Medicare subscriber has spent $200 out-of-pocket on such services.

Reliance on the National Association of Insurance Commissioners' coverage standards may be a key weakness of the Baucus Amendment, but the minimum loss ratios will serve to assure reasonably good value no matter what the coverage. If there is a good chance that the voluntary nature of the program will work, organizations representing the elderly have an opportunity to lobby for more substantial coverage standards on a state-by-state basis and thereby enhance the success of the law.

III. LIFE INSURANCE

The Problem

Few elderly are in the market for life insurance, but most older Americans probably continue to maintain contacts with life insurance companies by: paying premiums on policies purchased years earlier; keeping old policies in force on a paid-up basis; and receiving annuity or interest income from policy proceeds left with the companies. Older persons with ample means often purchase life insurance for children or grandchildren.

A recent Federal Trade Commission report was highly critical of the life insurance business, particularly its failure to provide customers with meaningful cost information. Among the conclusions in the report were:

- Due to the complexity of life insurance, consumers are unable to evaluate the relative costs of different life insurance policies.
- There is a wide variation in prices for similar policies.
- The savings portions of cash value policies earn relatively low rates of return.
- Holders of older cash value policies, especially those that don't pay dividends, often receive very low rates of return on their savings.
- Cost information now given to consumers under the model cost disclosure regulation of the National Association of Insurance Commissioners is "bewildering."
- Consumers should be given rates of return on the savings portions of cash value policies. This would aid consumers in choosing between the two basic forms of coverage: term life insurance (protection only) and whole life insurance (a combination of decreasing protection and increasing savings, or cash values, that usually provides a level death benefit).

Unfortunately, the FTC report was the proximate cause of legislation by the Congress that removed the FTC's powers to "investigate and report on" the insurance business.

The Issues

A. Industrial Life Insurance

One of the FTC's earlier reports dealt with "industrial" life insurance, now referred to as "home service" life insurance, in which premiums on very small face amount cash value policies are collected by door-to-door agents monthly, and sometimes bi-monthly or weekly. The FTC report on industrial life insurance included these findings:

- Sales are made largely to low income persons.
- Policies are high in cost.
- Several policies are often sold on one life, compounding the inefficiencies of the business.

- Many lapse their policies within the first few years and get nothing back.
- More death benefits are paid to female insureds (57.5 percent), in contrast to conventional life insurance (75 percent male insureds).
- Most policies are paid up at death (62.5 percent).
- 82 percent of death benefits are less than $1,000.
- Regulation of the business is even weaker than that of the conventional life insurance business.

Companies that sell industrial insurance defend their practices by saying that:

- Poor persons otherwise would have no money to cover burial costs.
- Unit costs of small policies are bound to be higher.
- Some insurance is better than none.

Consumer Reports, however, in its November 1978 issue, said that:

- Industrial insurance "soaks the poor."
- Legislation banning future sales of weekly premium industrial insurance should be enacted.
- Expense limitations should apply to all other sales of industrial insurance.

B. Life Insurance Trusteeship

Perhaps the major impact that the life insurance business has on the elderly has gone unstudied: its trusteeship for billions of dollars of the proceeds of death claims and surrendered policies of those in retirement. The substantial increase in interest rates in recent years has made settlement option guarantees in life insurance policies worthless. Although most companies pay excess interest in connection with monies left under settlement options, rates of interest are usually much lower than on investments of comparable size and safety. Excess interest is usually not paid on a portion of the money left. Those who have already elected settlement options (at least of the monthly income variety) cannot change their elections. Those who will make these elections in the future, however, may need much more guidance about alternatives than they now receive. Outside investments are likely to be more remunerative, and one can often vastly improve his or her annuity income from a life insurance company by shopping around to see what options companies are offering on new purchases.

Many older persons holding life insurance policies on a paid-up basis might be better off to surrender them. Consider a $10,000 policy on the life of a person aged 70 that was written many years ago and is now paid up on a non-dividend-paying basis. Its cash value could exceed $8,000. The holder can choose between taking $8,000 now or having $10,000 go to the beneficiary on death. If the policy were cancelled and the proceeds placed in a 12 percent, 2½ year bank certificate, in 2½ years the bank account would be worth $10,637, or $637 more than the amount payable at death. The expectancy of life at age 70 is about 11 years for males and about 15 years for females. Although this is an extreme example (because most policies pay dividends when left on a paid up status and because it takes advantage of very high interest rates now available), it does suggest that the elderly might best fight inflation by applying this sort of benefit analysis to policies they continue to hold.

C. Graded Death Benefit Contracts

The type of policy most elderly would consider buying is a graded death benefit contract sold by mail without evidence of insurability. The policy's death benefit in the first year is usually 10 percent of the ultimate amount and grades into the ultimate after three or four years. The policy amounts (face amounts) available tend to be quite low for those over 65. For those in average health or better, such policies tend to be poor buys, in part because the insurer must anticipate a disproportionate response to its advertisements from those in relatively poor health.

D. Price Setting

A recent study of public attitudes about life insurance found that 20 percent of those surveyed thought state insurance commissioners set rates for life insurance policies. Nothing could be further from the truth. Insurance commissioners have no rate regulatory authority over prices charged for life insurance, and companies are free to set prices as high as they wish. State insurance commissioners can do virtually nothing to examine the fairness of the treatment of old policyholders. Consumers need to be educated about insurance prices, coverage and regulation.

RECOMMENDATIONS

The following section contains the resolutions that were developed and adopted by work group delegates at the mini-conference.

Resolution Topic: PUBLIC PARTICIPATION IN THE INSURANCE REGULATORY PROCESS

Statement of Recommendation: Be it resolved that:

The uniqueness of different state regulatory processes requires that a number of approaches be used to expand public participation in the insurance regulatory process. The method chosen by each state should meet the following criteria: (a) it must be an ongoing process; (b) knowledgeable consumer representatives must be involved; and (c) funding should be provided to accomplish (a) and (b). The goal of increased public participation will be attained only if the above criteria are met and if groups mobilize to take advantage of these new opportunities, as well as the traditional methods of making one's voice heard. Training for these representatives should also be provided to make their input more effective.

Resolution Topic: ENFORCEMENT OF THE EXISTING INSURANCE LAWS AND REGULATIONS

Statement of Recommendation: Be it resolved that:

1. State agencies with enforcement responsibilities should establish a formal mechanism to assure coordination of enforcement activities, such as establishing an *ad hoc* commission comprised of state enforcement agencies, industry, and elderly consumers to recommend methods to improve operation.
2. Adequate funding should be allotted to state enforcement agencies to enable them to more effectively administer existing statutes.
3. States should be encouraged to pass legislation to deal with the Medigap problem, and, at a minimum, they should meet those standards established in the Baucus Amendment.
4. Legislative and regulatory bodies are continually forced to decide whether a particular insurance product ought to be banned or its attributes adequately disclosed to prospective buyers. Each issue needs to be examined case-by-case; however, at the very least, adequate disclosure, including standardized disclosure forms, should be assured. States should be encouraged to examine the adequacy of their laws and regulations relating to all kinds of health insurance for the elderly.
5. States should be encouraged to actively establish and support effective no-fault auto insurance legislation.

Resolution Topic: CONSUMER EDUCATION AND INFORMATION FOR ELDERLY INSURANCE CONSUMERS

Statement of Recommendation: Be it resolved that:

1. Establishment of local consumer information systems to enable the elderly to obtain information on insurance should be encouraged. This should include strong volunteer support systems which incorporate industry resources.
2. More reliable consumer information on Medicare and other forms of insurance are needed.
3. Local peer counseling services should be encouraged to provide older persons information and assistance on insurance-related concerns. Counselors should be sufficiently trained and supervised to assure accuracy of information.

Resolution Topic: POLICY LANGUAGE

Statement of Recommendation: Be it resolved that:

1. Insurance policies should be written in clear, concise, understandable language.

Resolution Topic: PHYSICIAN ACCEPTANCE OF MEDICARE ASSIGNMENT

Statement of Recommendation: Be it resolved that:

1. Serious attention be given to a possible revamping of the process of setting reimbursement rates.
2. Incentives should be found to encourage higher participation by physicians.

Resolution Topic: MEDICARE CARRIERS

Statement of Recommendation: Be it resolved that:

1. Existing laws and regulations should be reviewed to insure that proper safeguards exist in instances where Medicare intermediaries also market Medicare supplemental insurance policies.

Resolution Topic: INADEQUATE EXAMINATION OF POTENTIAL FRAUD OR INACCURACIES

Statement of Recommendation: Be it resolved that:

1. The federal government should allow more generous payment to provide the intermediary and carrier with greater incentive to screen claims for fraud and accuracy, then insist that adequate screening be conducted before claims are paid.

INVESTMENTS

INTRODUCTION

Americans of all ages have been hurt by fraudulent investment schemes, but deceptive sales methods strike particularly hard at older people. The elderly are often caught in a financial vise created by a combination of declining income and rising expenses. The economic difficulties caused by this situation frequently tempt the elderly to respond to promotions offering the promise of quick financial gain. Careful budgeting and prudent financial planning may be discarded, and hard-earned funds squandered on risky speculations that falsely promise safety and large profits.

Some of the investment promoters who have trapped the elderly engage in hit-and-run telephone room operations. Others work through the mails. A number of shady investment dealers personally contact their victims. These promoters commonly have an awareness of the financial plight of many elderly people, and their ability to take advantage of it.

Several investment-related subjects are especially relevant to the interests and concerns of the elderly. The following sections concentrate on these topics, including:

- real estate investments;
- business opportunities; and
- inflation investments/financial counseling.

I. REAL ESTATE INVESTMENTS

The Problem

In the search for hedges against inflation, investment in real estate has zoomed. Casual analyses of profit claims realized from owner-occupied and other housing gave rise to shibboleths about all kinds of real estate investments. Books and special classes about the ease of making fortunes from real estate proliferated.

As a result of factors cited above, many Americans were convinced that owning real estate of virtually any kind was a one-way street to certain profits. Perhaps the greatest gap between promise and reality in real estate investments occurred with respect to the sales of undeveloped subdivision lots.

The land sales industry has flourished because of the growing interest in real estate investments. Sales expanded rapidly during the 1960's and early 1970's, when they peaked at an estimated $5.5 billion per year. After a brief downturn during the recession of the mid-1970's, sales again climbed and are now believed to total several billion dollars per year. In the United States there are approximately 7.5 million subdivision lots on 6 million acres of land (nearly 94,000 square miles), an area more than one and one-half times the size of the state of Florida. In the most recent industry survey, the average lot price was above $16,000.

Retired persons and those planning for retirement have been major buyers of subdivision lots. The two chief motives for these purchases were to make money needed to cover expenses during retirement or to have a building site for a retirement home.

Some buyers' expectations were realized. All too often, however, older Americans and others who bought subdivision lots to earn profits were victimized. The sellers' constantly rising and strong investment claims were frequently a cruel hoax. Various factors influencing resale value both between and within development projects often worked to the detriment of consumer financial interests. Consumers discovered, after spending thousands of dollars, that the developers' prices bore little or no relation to resale values. Lot owners who tried to resell their land years after their purchases learned that real estate agents usually had minimal interest in listing their lots for resale. Results were poor for the few lots which were listed, and many parcels could not be resold, even at a loss.

The elderly and other buyers who wanted a homesite were often similarly disappointed. Promised roads, utilities and amenities were not installed in many subdivisions because of developers' bankruptcies or other financial problems. In some projects, improvements were installed late, improperly maintained, and/or had costs far exceeding initial estimates. Many buyers were forced to pay the full price of the land and improvements to a third party such as a bank or mortgage company even though the seller had not completed all obligations.

People who signed installment land contracts for lots with poor prospects as investments or homesites faced a Hobson's choice: if they continued paying, their losses actually increased; but if they stopped paying, the seller could keep whatever they had paid *and* the land under the terms of the "forfeiture clause" included in many land sale contracts.

The Congressional perception that land sales abuses were bilking older Americans first surfaced during the early 1960's. In 1963 and 1964 the Senate Special Committee on Aging held hearings on interstate land sales practices which led its Chairman to conclude that "many buyers had been misled or duped by unscrupulous subdividers." Additional hearings in later years led to passage of the Interstate Land Sales Full Disclosure Act in 1968. One reason for its passage was that state land sales regulation was inadequate, particularly with regard to interstate activity.

The Land Sales Act went into operation in 1969 under the jurisdiction of the Office of Interstate Land Sales Registration ("OILSR") at the Department of Housing and Urban Development ("HUD"). The major focus of the Act and related OILSR regulations has been upon disclosures including:

- technical information on utilities;
- status of title;
- easements;
- location near towns; and
- some information on developers' obligations.

Unfortunately, the goals of the Land Sales Act have often been blocked by land industry sales practices. Indeed, land sales reached their peak after the Act was passed and have been high in recent years. The one-time disclosures mandated in federal property reports, given out only at the time of sale, tended to be insufficient for dealing with the purchase of distant lots in anticipation of future profits or use. The shortfall occurs in: consumer education about real property; the supply of competing lots in the market; and resale value of comparable lots. Buyer complaints reveal a lack of awareness of problems until an average of five years after a purchase, even though many problems occur much sooner.

OILSR, the Federal Trade Commission, the Department of Justice, and relevant state agencies have taken various actions to curb land sales abuses affecting the elderly and other consumers. Unfortunately, many problems remain, including:

- investment and development misrepresentations;
- the use of high-pressure and other improper sales tactics; and
- the failure to perform improvement obligations.

The Issues

A. Pre-Purchase Disclosures

The purchase of a subdivision lot requires the consideration of many complex factors. Federal and state disclosure laws may not adequately advise potential buyers of risks and other key facts relevant to their purchasing decisions. Additional or stronger disclosures may be needed to inform buyers of potential resale problems, the disparity between the seller's price and the resale value of land, and development risks. Land buyers need to be able to understand the contents and investment implications of current property reports.

B. Rescission Periods

Various state and federal laws provide rescission periods during which lands sales contracts can be cancelled. For example, federal law provides a seven-day period after a contract is signed during which the contract may be cancelled. However, seven days may not be sufficient for purchasers to review all materials and obtain competent advice.

C. Title to Land

With an installment land contract, the seller does not transfer title to the buyer until all payments have been made. Many people who have bought land using these contracts may face insurmountable barriers in obtaining clear title to their land. Reasons for this problem include multiple sales of the same lot, bankruptcy of the seller, failure to record the contract, and the assertion of rights by third party creditors without notice of the buyer's claims. Federal or state land sales regulations could require that developers using installment land contracts meet requirements, such as prompt recording of contracts and placing title in trust, to overcome these title problems.

D. Post-Purchase Update

Property reports, such as those required by the Interstate Land Sales Act, provide information which is supposed to be accurate at the time of sale. Subsequent significant changes, such as the developer's bankruptcy, must be included in future reports. Such reports, however, are not sent to previous land buyers. Federal or state disclosure statues could be amended to require notice of material changes affecting subdivisions to past purchasers. In view of the long distances that separate many buyers from their property and the passage of many years before some promises must be met, it may be unrealistic to expect land buyers to obtain periodic updates on their own.

E. Failure to Provide Promised Improvements

Improvements such as roads and sewer systems may not be installed as promised, even if the developer has contractual obligations to do so. Some states have escrow or bonding requirements which may significantly increase the likelihood that development claims will be fulfilled. Other states could be encouraged to enact such substantive requirements. A Model or Uniform Act might be proposed on the basis of laws and regulations in such states as Florida and California to avoid potential improvement problems.

F. Holder in Due Course Doctrine

In real estate transactions the seller may transfer the land buyer's obligation to pay for his or her lot to a third party. In effect, the seller of the land sells the consumer's contract, usually at a tremendous discount, to a third party such as a bank or mortgage company. The third party "holder" may be able to require the consumer to continue to pay even if the buyer has valid claims or defenses, such as fraud or nonperformance of the seller. As the result of an FTC Rule, that doctrine no longer applies to the sale or lease of goods or services.

G. Injured Buyer's Ability to Obtain Redress

Land buyers who have been defrauded or failed to receive promised improvements may lack the ability to take effective action on an individual basis. Individual buyers need to know about others who have been similarly injured by land sale abuses. Organizations representing elderly people or other groups might be able to play a role in facilitating contact among injured parties.

H. Legal Authority During Litigation

In cases where a developer has engaged in improper practices affecting past purchasers, it may still be possible to collect funds arising from such sales. If the funds

are dissipated or the developer goes into bankruptcy, injured buyers may be precluded from obtaining effective relief. More needs to be known about whether government agencies should be given greater powers to protect defrauded buyers during the period of litigation. Alternatives, including the expansion of private rights to help solve this kind of problem, warrant study.

I. Adequacy of Government Enforcement

A promoter's misrepresentations and other illegal activities may continue during many years of litigation. Federal and state authorities may need greater staff and other enforcement resources to put a prompt halt to improper land sales activities. Improved work coordination among relevant government officials might prove effective in enforcement procedures.

J. Licensing

Land company salespeople and officials who are prosecuted for improper activities in one state often move to another state to continue their deceptive conduct. Federal or uniform state licensing or registration requirements might be an effective curb to this problem.

II. BUSINESS OPPORTUNITIES

The Problem

Business opportunity firms offer investors the chance to own their own business. In the typical case, a "parent" company promises, for a fee, to establish a business for an investor. The company's services usually consist of:

- supplying the goods or equipment required to operate the business;
- securing retail accounts or locations for these goods or services; and
- providing whatever training or ongoing assistance may be necessary to operate the business successfully.

The businesses usually require little or no prior business experience, minimum training and modest investment of time and money. Examples of popular forms of business opportunities include vending machine routes and distributorships.

The elderly are particularly vulnerable to the claims of business opportunities. Such ventures appear to offer features ideally suited to their needs and interests:

- the opportunity to supplement income;
- emphasis on mature responsible people who can work without supervision;
- a business with flexible responsibilities that can be met as the owner chooses; and
- a business that does not require elaborate training or investment.

For example, an advertisement for a business opportunity appearing in a recent nationally circulated newspaper exlaims: "EARN $180.00 to $480.00 A WEEK - working at home - simple - easy . . ."

The businesses superficially appear especially well suited for persons with the maturity and responsibility to be their own boss while rarely creating excessive operational demands. Unfortunately, the experience of many investors demonstrates that the trumpeted attractions rarely materialize, and the total financial investment is often lost. The major reasons for these failures appear to involve sellers' false earnings claims, and broken promises to supply necessary goods and services or assistance in securing locations or retail accounts.

Investigations were conducted during the mid-1970's by state and federal agencies on behalf of the elderly and other consumers who were or could be victims of false claims by business opportunity firms. The studies revealed that consumers were taken advantage of through widespread deceptive and unfair practices. Among the factors identified as creating the atmosphere in which consumer abuses flourished were:

- the assumption of significant financial and personal risks by prospective investors when purchasing a business opportunity;

- reliance by investors on the sellers' purported expertise and stability;
- an imbalance in information between the investor and the seller during pre-sale negotiations (the investor often never obtained complete or accurate data about vital aspects of the proposed business or the risks being assumed); and
- the absence of a ready and available source of data for the prospective investor to learn about the business or the people operating it.

The Issues

A. Pre-Sale Information

Such factors as those listed above made it clear that prospective investors needed to receive reliable, pre-sale, written information about the proposed investment. In this way investors could obtain information about vital aspects of the proposed business so they could consult with business advisors and make a careful review. The potential for seller misrepresentations would be reduced by requiring that information in writing and sufficiently prior to the sale to enable the prospective investor to verify the information being disclosed.

An FTC rule entitled "Disclosure Requirements and Prohibitions Concerning Franchising and Business Opportunity Ventures" requires sellers of business opportunities to provide a disclosure document to potential investors. This document contains information about the seller, the nature of the business and the terms of the proposed agreements. Additional information must be furnished if any claims are made about actual or potential earnings. Copies of the proposed business agreements also must be furnished. All of this information must be given to prospective investors at least ten days prior to the time that an investor can purchase the business opportunity.

The FTC's rule is limited to pre-sale disclosure of material facts. The Commission felt that if the parties knew in advance what the terms and conditions of the proposed relationship would be, they would be able to negotiate a mutually satisfactory arrangement. Accordingly, no attempt was made to dictate specific contract terms such as termination rights, required product purchases and noncompetitive clauses.

B. Economic Risk

These purported "advantages" of business opportunities only seek to obscure the high economic risk which accompanies their purchase. Such risks are especially crucial to elderly investors who generally have a lessened capacity to reverse major economic losses. Many business opportunities' life (or presence in a community) is measured by the length of time it takes for law enforcement agencies to commence an investigation. The Business Opportunity Clearinghouse, which is associated with and indirectly funded by the Business Opportunity Task Force of the National District Attorney Association's Economic Crime Project, has been monitoring activities of business opportunity firms for the past two and one-half years. During this time the Clearinghouse has identified 1,618 business opportunity firms and estimates that the marketing practices of 90 percent are "troublesome." The efforts of most of these firms appear to be directed solely at selling a business opportunity. Once the sale is made and the fee is collected, little or no performance follows.

C. Investor Protection

Required pre-sale disclosures do not distinguish between good offerings or bad offerings. No means of financial protection for a bad investment is provided to investors. Some minimal "fair, just, and equitable" standards to the proposed investment could be established before it can be offered to potential investors. For example, requiring the seller to post a performance bond and guarantee that money is on hand to satisfy any legal judgment obtained by an investor could help assure compliance with contract terms. Another option could

require sellers to place all monies paid by potential investors in escrow pending the seller's performance of its promises under the contract.

Attention must be paid to identifying and addressing the most effective and appropriate means by which elderly consumers and all Americans can be made aware of and protected against false and misleading claims from business opportunity firms.

III. INFLATION INVESTMENTS/ FINANCIAL COUNSELING

The Problem

Older Americans, quite logically, feel the need to protect the value of the assets they have saved for retirement. Current economic turbulence is forcing many older people who live on fixed incomes from retirement or pension plans to turn to unusual forms of investment to protect their savings. Promotions for sales of items such as precious metals and stones are often targeted directly at the elderly. Sales of these investments may be touted over the phone or through mailings directed at older Americans. It is frequently difficult to evaluate the investment risk or potential liquidity of an increasingly exotic array of products sold as inflation hedges.

Another investment-related problem that seriously affects the economic health of older Americans is reliance on financial planning or counseling services. The elderly may have difficulty obtaining sound financial-planning advice to protect themselves against unscrupulous investment practices. Financial planners often lack the expertise to advise their clients about diverse and sophisticated investment alternatives.

The Issues

A. Value of Inflation Investments

The amount paid for hard assets sold as investments against inflation may be far above their market value. Additionally, there may not be a ready market, as often claimed, in which to liquidate an asset if cash is needed quickly. Also, consumers seeking to sell hard assets for cash may be paid far below the true market value for collectibles and assets such as jewelry which have been amassed over a lifetime.

B. Objectivity of Financial Counseling

There is a fundamental question that arises around the issue of financial counseling apart from those explored in other sections of this paper: Is the advice of some financial planners truly detached? Although planners receive fees for their services, most of their income comes from commissions on the financial products they sell to their clients. It has been alleged that a serious conflict-of-interest question arises for many financial counselors since dubious investments often carry high commissions to lure planners away from less lucrative but more sensible products.

C. Regulation

With the sale of investment products and the financial planning industry burgeoning under the impact of inflation, it has become increasingly difficult for regulators and law enforcement agencies to keep pace. The state and federal agencies responsible for regulating financial services and the sale of investments could better assist older Americans in ensuring that they obtain sound financial advice and in preventing fraudulent or deceptive investment schemes. Consumer education might prove particularly helpful in this area. Channels of information to keep responsible federal agencies informed of difficulties older persons are experiencing in investments and financial planning services need to be investigated.

RECOMMENDATIONS

The following section contains the resolutions that were developed and adopted by work group delegates at the mini-conference.

Resolution Topic: REGISTRATION OF FINANCIAL PLANNERS AND ESTATE PLANNERS

Statement of Recommendation: Be it resolved that:

1. Financial planners and estate planners should be held to a standard of competency through state registration.
2. Each state should establish a board consisting of lay persons and experts in the field of financial and estate planning who would review, upon complaint, the competency of the registrant.

Resolution Topic: NEED FOR CONSUMER EDUCATION

Statement of Recommendation: Be it resolved that:

1. All sectors, at all levels of government, educational institutions, private industry, the news media, senior citizen centers, and other private groups work to improve the delivery of accurate, simplified information, in all widely used languages, on investments and personal financial counseling for older Americans.
2. Methods to be considered should be the development of a source handbook tailored to older Americans where necessary.

Resolution Topic: INVESTMENT INFORMATION: COST AND ACCESS

Statement of Recommendation: Be it resolved that:

1. Organizations such as competent investment clubs should be encouraged to benefit the elderly who have not been exposed to sophisticated financial language and procedures.
2. The cost of assuring access to information for investment should be supplied by federal or state agencies in conjunction with private industry and trade associations.

Resolution Topic: NEED FOR PLAIN LANGUAGE DISCLOSURES AND DEVELOPMENT OF A GLOSSARY

Statement of Recommendation: Be it resolved that:

1. In investment transactions full disclosure should be promoted in simplified language that considers cultural background and level of education.
2. A glossary of definitions of basic terms used in investment programs should be developed based on cultural background and educational level.

Resolution Topic: REAL ESTATE FRAUDS

Statement of Recommendation: Be it resolved that:

1. Existing disclosure requirements are presently inadequate and should be more detailed to disclose such information as who gets exact fees and commissions, up-front costs, and the handling of deposits in escrow and interest-bearing accounts.
2. Jurisdiction should be expanded to permit federal, state and local agencies to address deceptive sales and advertising practices.
3. There should be adequate bonding requirements to ensure satisfactory completion of sellers' promises and legal obligations.

Resolution Topic: LACK OF EFFECTIVE ACCESS TO COURTS

Statement of Recommendation: Be it resolved that:

1. In transactions involving investments by the elderly and certain dollar amounts, the contract should provide for a dispute resolution system which is fast, low cost, easily accessible and fair, such as arbitration, small claims courts, night and weekend courts.
2. Aging organizations should create group legal services programs for their members.
3. The expertise of retired lawyers should be used in the same way that the expertise of retired executives is now used.
4. Programs in existence today, such as third-party dispute resolution, arbitration and mediation, should be adequately funded, staffed and fully implemented.

PRESCRIPTION DRUGS AND MEDICAL APPLIANCES

INTRODUCTION

Prescription drugs and medical appliances, particularly hearing aids and eyeglasses, are crucial health care items for all Americans, especially the elderly. The consumer issues inherent in these areas are discussed in the following sections.

I. PRESCRIPTION DRUGS

The Problem

Prescription drugs now cost American consumers more than 9 billion a year. Expenditures by Americans 65 and older account for 25 percent or $2.5 billion. Increased demand and continuing inflation will further escalate drug prices.

In an effort to save consumers money on their prescription drug bills, 47 states and the District of Columbia have enacted drug product selection laws which allow pharmacists to substitute a lower-priced generic drug product for the brand-name drug product prescribed by the physician. Currently, only Texas and Indiana prohibit substitution. Oklahoma allows substitution by virtue of an opinion by the state Attorney General. These laws supersede state anti-substitution laws, which prohibit pharmacists from dispensing a different drug entity, or a different brand from the one prescribed.

State statutes authorizing drug product selection vary widely. In most states, substitution is at the discretion of the pharmacist; however, other states mandate substitution. Some state statutes require that all cost savings from substitution be passed on to the consumer. Other states require that a specific percentage be passed on; a few states don't specify any amount. All states allow a physician to insist upon the use of a particular brand name drug product, but the means by which this can be accomplished differ from state to state. Some states require that a pharmacist make substitutions only from drugs listed in a "positive formulary." Other states prohibit substitution of drugs listed on a "negative formulary" or have no formulary at all. Patient notification of substitution is required in some states.

Just as the provisions of state drug production selection laws vary, so do their rates of effectiveness. A study by researchers at Wayne State University showed an 18-20 percent rate of drug product selection in Wisconsin as compared to a 1.5 percent rate in the neighboring state of Michigan. Although most of the state drug product selection laws are relatively new, many states have been examining the effectiveness of their legislation and have begun to amend their laws to increase substitution and boost direct savings to consumers and public programs such as Medicaid.

To assist states interested in modifying their drug product selection laws or enacting new legislation, the Federal Trade Commission and the Food & Drug Administration have proposed a Model Drug Product Selection Act. This model law, based on a two-year study of generic substitution by the staff of the Federal Trade Commission, permits a pharmacist to substitute a lower-priced therapeutically equivalent drug product for a brand name product prescribed by the physician, unless the physician handwrites "medically necessary" on the prescription. The model law recommends the use of a positive formulary based on the FDA's list of therapeutically equivalent drug products. It also provides that the consumer must be notified when drug product selection has occurred and gives the consumer the option of insisting on the brand prescribed.

Potential savings to consumers from drug product selection have been estimated at $400 million a year by economists at the Federal Trade Commission; yet ac-

tual savings to date have fallen far short of this estimate, since drug product selection rates have been low. Many factors contribute to the slow success of state substitution laws.

The Issues

A. Understanding the Laws

Laws permitting substitution are relatively new, and many physicians, pharmacists and consumers are confused about how the laws work and what they require.

B. Disincentives

Many laws permit substitution but create economic disincentives by not allowing pharmacists any recompense for costs incurred in locating, stocking, and dispensing lower-cost generics. In some states where physicians are allowed to prohibit substitution by signing a pre-printed prescription blank which states that the pharmacist must "dispense as written," substitution is prohibited 50-75 percent of the time. Some pharmacists are concerned about possible liability risks and are therefore deterred from selecting drug sources as often as they would otherwise. The combination of these and other factors may account for the low overall rate of drug product selection.

C. Making the Laws More Effective

The enactment of state drug product selection laws and the repeal of antisubstitution laws have resulted in consumer savings which, though as high as predicted, have been an important first step. The issues that remain, now that all but two states allow substitution, are whether some state laws need to be amended to maximize drug product selection, whether any federal legislation in this area would be of benefit, and how best to inform pharmacists, physicians, and consumers about the impact of these laws.

D. Drug Product Selection and the Elderly

If the prospects of lower drug prices are important to the American public as a whole, they are doubly significant to Americans over 65 years of age. This group uses a disproportionately high amount of prescription drugs and has a disproportionately low income.

The elderly's share of drug expenditures is large. Data collected in 1973 show that people 65 and older have over twice as many prescriptions to be filled each year as those under 65. Per capita estimates vary according to source and year, but the elderly also spend more on drugs than other age groups. Their expenditures can be explained by the higher incidence of disease in older Americans.

- Eighty percent of the elderly, twice the number of those under 65, suffer from one or more chronic diseases.
- In fiscal 1978, the elderly's annual drug expenditures were $133 per person, nearly double the $68 average for all ages.

High drug costs among the elderly are exacerbated by relatively low, often fixed, incomes. In 1979 the Bureau of the Census reported the average income of those over 65 ($11,316) to be only 57 percent that of the population in general ($19,684). Also, poverty rates among the elderly increased from 14 percent in 1978 to 15.1 percent in 1979.

Because of these higher drug expenditures and lower income levels, the elderly spend more of their income on medication than other age groups. For those suffering from chronic maladies the burden can be extraordinary.

According to a 1974 National Retired Teachers Association—American Association of Retired Persons survey of 2,000 of their members, all of whom used a large number of prescription drugs due to illness and/or injury, at least 10 percent of their income was spent on medication. In dollar terms, the annual drug expenditures of those responding ranged from $200 to $1,000. A large percentage of this figure must be paid directly by the elderly because of the relatively insignificant role of private third-party drug payment plans

and the inability of many who live on poor and near-poor incomes to gain Medicaid eligibility. According to the HEW Task Force, the elderly in 1979 had to pay 84 percent of their prescription drug costs out-of-pocket.

Because they pay such substantial yearly medical expenses, older Americans stand to benefit greatly from effective drug product selection laws. High prescription drug costs force some elderly to go without medication to buy other necessities. To the extent that drug product selection lowers prices, it could also influence under-medication.

E. Price Variations

Prescription drug prices vary from pharmacy to pharmacy. Attention must be paid to methods of education, advertising and promotion that provide the best means for the elderly and all consumers to receive accurate comparative price information. Consumer price surveys may be one way of collecting and disseminating information on drug prices.

F. "Look-Alike" Drugs

Many generic substitutes are identical in appearance to their brand name counterparts. Older patients may be more likely to comply with their therapy regimens if the generic drugs they are given look like the brand-name drugs they took previously. Legislation may be enacted requiring that look-alike drug products bear the name, trademark number, or some other identification code to differentiate them from brand-name drugs. Generic drug manufacturers have claimed that imprinting identification codes on pills or capsules would result in substantial expense, possible lowering the amount of savings.

II. HEARING AIDS

The Problem

Approximately 15 million Americans suffer from hearing problems. Statistics indicate that more than 40 percent are over 65, more than 50 percent are over 60, and that of the 1.2 million Americans who live in nursing homes, 90 percent have a significant hearing impairment.

It is not surprising to learn that the elderly hearing impaired population has low incomes. In fact, in 1971 dollars, 60 percent of families with hearing-impaired members had incomes lower than $5,000. Furthermore, available data indicate that the elderly hearing impaired are subject to other debilitating physical conditions. For example, over one-fourth of the hearing impaired population over 65 is further hampered by a visual problem. Many elderly believe hearing impairment is part of the natural aging process and irreversible. Worse yet, many refuse to admit they have a problem because it might signify a general failing of health.

These problems provide a context for a review of the problems involved in the marketing of hearing aids. The issues discussed in this paper are particularly relevant to individuals who have become hearing impaired later in life, compared to those who have always experienced hearing difficulties. Elderly consumers, newly hearing-impaired, are at a distinct disadvantage in dealing with the numerous unfair high pressure sales tactics that have often characterized hearing aid sales.

A large part of these abusive practices has been claims about the relative ability of hearing aids to restore hearing and enable the wearer to return to "normal" participation in day to day affairs. In fact, amplified hearing (which is what an aid can provide) is far from normal or natural. Moreover, many hearing impaired individuals are simply unable to adjust at all to the techniques of aided hearing. Other misrepresentations regarding the performance and features of hearing aids have been documented, including:

- unsupported superior performance and uniqueness claims;
- false claims that aids can be "prescribed" like eyeglasses;
- claims that aids can actually halt or retard the progression of physiologi-

cal and degenerative hearing loss; and
- various claims regarding hearing aid features and the need for two aids rather than one.

Additional abusive practices have occurred in face-to-face encounters between salesmen and prospective purchasers. Since more than 60 percent of all aids are sold in the home, it is important to note that unannounced visits frequently occur, often after consumers respond to offers of "free" gifts or literature. Other problems include attempts by sellers to pressure consumers into believing that their hearing will deteriorate unless they wear an aid, and other attempts to inflate the credibility of their sales pitches by adopting titles that misrepresent their professional qualifications.

The various abusive practices that have occurred have been compounded by two factors. First, the average yearly cost of owning and operating a new aid is nearly $400, $800 for binaural amplification (aid for both ears). Second, there is an inherent risk that the purchase of an aid will provide no benefit to the consumer. There is no way to tell in advance, with any real precision, whether a purchase will prove essentially worthless. Also, the cosmetic aspect of a hearing aid can determine its worth and subsequent use by the hearing impaired. Against these basic facts—high expense and high risk—the fact that questionable or even unlawful marketing practices occur frequently is cause for real concern.

The Issues

A. Industry Self-Regulation

Attempting to address these multiple problem areas, actions and proposals for actions have been undertaken by the hearing aid industry itself and by the government. The National Hearing Aid Society (NHAS), a trade association of hearing aid sellers, has developed a self-policed consumer protection plan. Apparently this was done in response to the attention focused on the conduct of its members by Congressional inquiries and proposals for action by the FTC, whose consumer protection plan includes:

- a requirement that all first time hearing aid users receive a medical evaluation before purchase;
- the availability of a rental option for those consumers who ask for it;
- more rapid grievance handling procedures; and
- continuing education and training for hearing aid sellers.

The NHAS represents many hearing aid sellers, and its members sell the majority of aids in the U.S. Nevertheless, many hearing aid sellers do not belong and are not subject to its provisions.

B. Federal Regulation

The Food and Drug Administration considers hearing aids to be regulated medical devices. FDA requires a medical examination before an aid can be sold to any consumer, unless the consumer waives the requirement. FDA also requires sellers to give each prospective hearing aid purchaser a User Instructional Booklet before purchase, review the booklet with the consumer, and allow the consumer the chance to read it prior to purchase. Each manufacturer prepares a User Instructional Booklet for its own products. The User Instructional Booklet must include the following information:

- the technical capabilities of hearing aids;
- the use and care of the instrument;
- the importance of obtaining a medical evaluation before purchase; and
- the need to ask for a trial rental if the purchaser is concerned about his/her ability to adjust to an aid.

There is little data available on the extent to which sellers adhere to the medical evaluation requirement or the requirement to review the booklet with consumers prior to purchase. There is also little data available on the extent to which the FDA monitors or enforces these regulations.

The Federal Trade Commission has considered issuing a rule to allow every hearing aid purchaser a 30-day trial period. If, during that period, the aid proves to be unsatisfactory, the purchaser would have the right to return it for a refund of the purchase price less a prescribed cancellation fee to compensate for the one-month rental, batteries, and custom-made earmold. The Commission's rule would not require any disclosures in sales transactions or prohibit any representations about what hearing aids can do. It would rely upon the right to cancel the purchase as an indirect remedy for the numerous abusive practices catalogued earlier. It would act as a deterrent to involvement in those practices because sellers would want to avoid creating exaggerated expectations about the performance of aids that might prove unfounded during the trial period. It is anticipated the proposal will be considered by the FTC sometime in 1981. If adopted, it will then be submitted for Congressional review thereafter. Even if Congress fails to disapprove the regulation, the affected parties may challenge the regulation in court, which might further postpone its effective date.

III. VISION CARE

The Problem

Good eyesight is important for everyone, but without some type of corrective lens, over 50 percent of the general population would not enjoy optimal vision. Among those over 65, 94 percent require some type of optical correction. In addition to vision problems, the elderly experience a higher incidence of eye disease, need frequent lens changes, and require stronger-than-average corrective lenses. Yet because many elderly earn low or fixed incomes, they may be least able to afford the cost of regular vision care.

Consumer education efforts to make the elderly more aware of their vision care needs may help enhance their visual well-being and ensure adequate access to quality vision care at a reasonable cost.

The Issues

A. Eye Disease and Treatment

One common eye disease affecting the elderly is cataracts—a clouding of the lens within the eyeball that results in blurred vision. Some cataracts never advance to the stage where surgery is required to remove the clouded lens. However, if an operation is deemed necessary, the natural lens which has been surgically removed must be replaced for the eye to focus clearly. Cataract patients must wear cataract eyeglasses, contact lenses, or have an "intraocular lens" implanted to replace the defective natural lens.

Cataract eyeglasses are probably the least expensive option for consumers. However, because of their thickness and distance from the eyes, they often make objects look larger and closer than they really are or distort peripheral or side vision. Contact lenses give more natural vision without the distortion of side vision, but physical limitations make it difficult for many elderly to insert and remove contact lenses on a daily basis. The intraocular lens, an experimental device, actually replaces the cloudy natural lens and allows the eye to focus without the need of a cataract spectacle or contact lens. The use of intraocular lenses has grown considerably during the past few years, but many problems have arisen, some of which have necessitated surgical removal of the lens. Because the intraocular lens is an artificial lens inserted in the eye, it can be rejected and require another operation to remove it.

"Informed consent" is essential to the safe and effective use of intraocular lens transplant surgery, especially in the short term. There is now no specific, comparative information required or available for consumers about the relative risks of such lenses, or about alternative methods of treatment.

Some people assert that the continuous wear contact lens has made the intraocular lens obsolete. Continuous wear contact lenses do not present the risks associated with intraocular lenses, offer nearly as

good vision, and are designed to be worn for weeks or even months. The use of the intraocular lens for cataract patients might be questioned because of its higher complication rate and the development of continuous wear contact lenses as a satisfactory alternative.

B. Eye Examinations

There is considerable disagreement between organized opthalmology and optometry over the scope of the eye examinations which optometrists are qualified to perform. Although its is generally agreed that optometrists are qualified to measure the refractive status of the eye and fit people with corrective lenses, there is disagreement over the optometrist's ability to diagnose and treat eye disease.

The optometry practice acts allow optometrists to detect eye disease and refer a patient with such conditions to the appropriate medical practitioner, but their use of diagnostic and therapeutic pharmaceutical agents has become controversial. Optometrists currently serve as the point of entry into the vision care system for approximately 60 percent of the American public. Thus, their ability to use these agents may result in the detection of more eye disease. About 25 states permit optometrists to use drugs for diagnostic purposes if they have completed certain educational requirements in the use of such pharmaceutical agents. More needs to be learned about the effectiveness of detecting eye disease through the use of pharmaceutical agents.

C. Access to Vision Care

Eliminating restrictions on the permissible location of optometric and optician practices can make vision care more accessible to most consumers, including the elderly. But more conveniently located practices cannot make care available to those who are immobile. The elderly who are unable to drive, have limited or no access to public transportation, are disabled or confined all have special needs.

The importance of access to vision care for those with limited mobility needs to be more widely understood. Attention must be directed toward programs that meet the special needs listed above. Mobile vision-care units might be one feasible alternative. Private practitioners also need to be aware of the special needs in their localities so they can participate in the development of care programs that meet those needs.

D. Preventive Care

Preventive vision care is especially important to the elderly, and surveys show that it is inadequately practiced. Glaucoma can be seriously debilitating and its incidence rises with age, therefore, examinations to detect glaucoma should be routine among the elderly. But surveys show that only about 25 percent of those 65 or older receive a glaucoma test in any given year and that less than 60 percent have ever had a glaucoma test.

Although lower prices and more convenient locations could increase the practice of preventive care, consumer education is necessary to increase the understanding of the need for such care. The efficacy and reliability of tests and associated risks need to be brought to the attention of elderly consumers. Existing programs to make the elderly aware of their vision care needs must be studied and possibly developed as models for larger scale consumer education efforts. The role of vision care professionals in developing and supporting such programs should also be examined.

E. The Costs of Vision Care

Inquiry into the price of vision care has shown that a wide range of prices exists for comparable prescription eyewear. High prices may be forcing the indigent, the elderly, and many middle-income Americans to wear outdated and ineffectual glasses, or to go without corrective lenses. The Federal Trade Commission is examining several types of public and private regulations which limit or ban "commer-

cial" practice by vision care providers. These regulations prevent a practitioner from working for a non-professional corporation; from locating a practice in a high-traffic location (such as a department store); and from operating branch offices.

These restrictions tend to prevent opticians, optical chains and department stores from competing with solo-practicing optometrists since they cannot hire optometrists to offer eye examinations. They also prevent individual practitioners from locating in areas such as shopping centers which are highly visible to consumers and where the potential for developing higher-volume practices exists. The growth of optical chains and other high-volume practices, which may be able to charge lower prices than small independent practitioners, is inhibited by these restrictions. Proponents of commercial practice restrictions, however, argue that they are necessary to maintain professionalism and assure high-quality vision care.

The FTC recently conducted an economic study to determine whether the price and quality of optometric services are affected by restrictions which limit advertising and the practice of optometry in commercial settings. The study results indicate that elimination of these restrictions would result in significantly lower prices (as much as 33 percent) and would not lower overall quality. When comparing quality of service provided by commercial providers and non-commercial providers, the results show no difference between the two types of providers with respect to prescription accuracy, accuracy and workmanship of the eyeglasses, and the extent of unnecessary prescribing of corrective lenses. In one area of quality—the thoroughness of examination—results show that commercial providers on the average performed less thorough eye examinations than non-commercial optometrists.

The study seems to suggest that the potential benefits of commercial practice are increased access to and lower costs for eye care without a compromise in the overall quality of the care delivered. The FTC staff recommends that total bans on commercial practice be removed, but that states remain free to regulate specific abusive practices. Even if commercial practice restrictions result in higher prices and limit accessibility to vision care, there may be some legitimate quality of care concerns associated with commercial practice. If so, ways to protect the public health and safety through less restrictive means than a total ban on commercial practice should be examined.

F. Quality of Vision Care

The study by the Federal Trade Commission suggests that there are substantial differences from practitioner to practitioner in the thoroughness of eye examinations. The study showed that only slightly more than half of the practitioners tested for glaucoma and well under half examined the cornea with a lamp designed for that purpose. The study was conducted using younger persons with only routine vision problems and, hence, may not represent the kinds of examinations that would be provided to elderly patients. However, the study does suggest that eye examinations may vary widely in their thoroughness.

Because they face a higher incidence of debilitating eye disease and because they often have difficult vision problems, the elderly have a special interest in receiving regular thorough eye examinations. Standards for eye examinations must be established on either a mandatory or voluntary basis, and monitored to determine if they increase the cost of vision care to those requiring or desiring only routine examinations. If standards are established, the monitoring of levels of compliance will become an important issue. Consumer education might provide a reasonable alternative to institutionalized monitoring of the quality of eye examinations.

RECOMMENDATIONS

The following section contains the resolutions that were developed and adopted by work group delegates at the mini-conference.

Resolution Topic: DRUG COSTS

Statement of Recommendation: Be it resolved that:

1. State generic drug laws should be amended and standardized to include the following conditions: (a) Prescribers should be required to provide in their own handwriting whenever drug product selection is to be prohibited; (b) In order to provide an incentive for drug product selection, the laws should provide a sharing of savings between consumers and pharmacists, with a substantial majority of savings being passed on to the consumers; (c) The laws should provide for generically written prescriptions that require the lowest priced product, consistent with professional judgment, to be dispensed; (d) State laws should provide for educational programs directed at consumers and professionals to encourage greater use of lower priced generically equivalent drug products.
2. The White House Conference on Aging should call for the establishment of a committee, including both private and public representatives, to produce a draft model drug product selection bill for submission to all of the states.
3. Prescription drugs should be included as a covered benefit under the Medicare program to encourage greater use of lower-cost, generically equivalent drug product.

Minority Opinion: Including prescription drugs under Medicare at this time would introduce a danger of overprescribing. Alternate methods of prescription drug cost containment should be evaluated, and other mechanisms, such as patient responsibility for a portion of drug costs, should be established.

Resolution Topic: CONSUMER EDUCATION

Statement of Recommendation: Be it resolved that:

1. Consumer education should be supported and encouraged at all levels to provide elderly consumers with the facts on: (a) how medications and medical devices work and their limitations (e.g., that drugs are often not appropriate); (b) the proper utilization of drugs and medical devices and how to avoid common medication problems; (c) how to ask questions of and communicate effectively with physicians, suppliers of medical devices, and pharmacists; (d) how to save money on medical devices and medications by comparison shopping and using generics; (e) rational preventive care skills and use of over-the-counter drugs; (f) how to recognize and resist deceptive advertising practices and quackery.
2. These skills and information should be made available through: (a) easily readable labels, patient package inserts (PPIs) in language lay people can understand, explanations by the physician at the time of prescribing, and the use of patient profiles; (b) training to help professionals, emphasizing respect for consumers and the importance and skills of communicating clearly; (c) special training for senior leaders, and the use of senior centers and other community organizations, such as libraries and schools, as a source of information; (d) the establishment of impartial information centers reachable by toll-free numbers.
3. Consumer protection agencies at all levels should make greater use of publicity to combat fraud and advance consumer interests.

Minority Opinion: Printed information should not be limited solely to PPIs. Instead, alternative methods to describe proper drug use and possible adverse reactions to consumers should be developed which are less expensive than PPIs and which provide drug information before rather than after the drug has been purchased.

Resolution Topic: DECEPTIVE ADVERTISING OF DRUGS

Statement of Recommendation: Be it resolved that:

1. The Federal Trade Commission should study the issue of whether or not television advertising encourages the use of non-prescription drugs when they are not needed by the individual, and examine whether they may be harmful.
2. The FTC should examine deceptive advertising regarding false claims in medical results and cost savings.

Resolution Topic: PRESCRIBING OF DRUGS AND MEDICAL DEVICES

Statement of Recommendation: Be it resolved that:

1. The Department of Health and Human Services should investigate patterns of prescribing to encourage a more rational prescribing of prescription drugs to achieve more appropriate care as well as cost savings.

Minority Opinion: A prescribing physician or associate should not be involved, directly or indirectly, with the sale of the prescribed product or device. If he is involved in the sale of medical devices or drugs, he should be qualified as to competency by passing an examination required by a licensing board or regulatory body pertaining to fitting and dispensing of the devices or products, and obligated to disclose that he is also a salesperson.

Resolution Topic: SENIOR CONSUMER COOPERATIVES

Statement of Recommendation: Be it resolved that:

1. The National Consumer Cooperative Bank should be strengthened to serve the needs of consumers by providing sound loans and technical assistance for drug and health care cooperatives.

Resolution Topic: CONSUMER PARTICIPATION

Statement of Recommendation: Be it resolved that:

1. Effective participation of consumers should be encouraged by requiring at least 50 percent of the members of licensing and regulatory boards to be public members.
2. Such public members should represent consumer organizations and receive training and support necessary to fulfill their role.

Minority Opinion: The control of licensing and regulatory boards should remain within the professions. Consumers should be adequately represented on these boards, but should not constitute 50 percent of their composition.

PRIMARY HEALTH CARE PROVIDERS

INTRODUCTION

The availability, affordability and accessibility of quality health care services are particularly important to the elderly since they use health systems to a greater extent than younger persons. The elderly represent only 11.2 percent of our population, but account for 29 percent of the nation's total health care expenditures. During the next decade we can expect to see a continuing upward spiral in health care costs. At the same time, there will be continued growth in the size of the aged population which has grown from 9.8 percent to 11.2 percent of the total in the last decade and is expected to increase to 17.2 percent by 2025. This growth will create the need for more primary health care delivery systems designed to provide care to the elderly.

According to a recent report by the Senate Special Committee on Aging, there is a growing concern that not enough is known about the most effective and economical ways to structure the wide range of long term health care services which will be required to meet the needs of the aged population. A large portion of the health care system will have to be refocused to handle the long term and chronic health problems which are common among the elderly. The present system, largely due to Medicare policy, tends to concentrate on acute and not chronic problems. It is oriented towards crisis intervention rather than preventive care, and emphasizes institutional (hospital) based health care instead of ambulatory and outpatient services.

The following sections discuss various issues associated with two methods of expanding primary health care delivery: nurse practitioners and denturism. Consumer problems and issues of special relevance to the elderly are discussed as they relate to the development of these two areas of health care services.

I. DENTURISM

The Problem

The laws of nearly all states prohibit non-dentists from selling complete dentures directly to patients. They require that impressions be taken and dentures be fitted only by dentists. The laws of Oregon, Arizona, Colorado and Maine are exceptions. In Oregon an initiative (carried by a large majority of the voting public after a heated campaign) will permit denturists to provide complete dentures directly to the public, independent of a dentist's practice.

These prohibitions do not exist worldwide. The most notable examples of a different system may be found in most of the provinces of Canada where "denturists" are authorized by law to provide complete sets of dentures directly to members of the public.

In the United States the generally high cost of denture care and the maldistribution of dentists in certain parts of the country, particularly in rural and in inner city areas, have contributed to the emergence of a substantial underground market in illegal denture care by denturists. Dental laboratory technicians are providing primary complete denture care illegally. Many members of the dental laboratory industry in the United States, citing the Canadian experience and the many satisfied patients of illegal denturists in the U.S., claim that the technical skills of the members of their profession qualify them to provide such care competently. They have been attempting to legitimize denturism in various states, but with only very limited success.

The problem of denturism in the United States, simply stated, is whether it should be permitted or not and, if so, by what means. Those favoring denturism argue that:

- it will introduce needed competition in the providing of complete denture care;

- it will be likely to lower denture care prices significantly; and
- it will add substantially to the number and distribution of providers of such care throughout the country.

Those opposed to relaxing the prohibitions against denturism argue:

- it will lower the quality of denture care provided to the public;
- it will increase the magnitude of health risks to which the edentulous (toothless) public is exposed in the course of obtaining such care; and
- it will unwisely fragment the delivery of dental care to the public.

A compromise solution to this problem which has been adopted in Colorado, Maine and Arizona authorizes dental laboratory personnel to provide primary complete denture care directly to the public under the general supervision of a dentist on the same premises.

The Issues

A. Costs

Currently, the elderly pay approximately 97 percent of their dental costs out-of-pocket. Medicare does not cover dental services, and the number of states covering dental care or dentures under their Medicaid programs continued to decline in the wake of budget cutting.

B. Need for Denturist Services

The need for denturist services increases sharply with age; persons between the ages of 65 and 74 are nearly five times more likely to be edentulous than persons aged 35 to 44. About 51 percent of all persons over age 65 are edentulous.* Almost twenty-five percent (24.8 percent) of all Americans over age 65 need to have a complete upper or lower denture (or both) constructed, either because they have no dentures at all or because the dentures they have are so ill-fitting they cannot be repaired. These people suffer the physical discomfort of sores, reduced ability to chew food, and poor appearance; they risk a greater inability to wear dentures in the future; they forego the protection which might be provided by a screening for oral disease; and they suffer psychological humiliations which significantly detract from the quality of their lives.

The proponents of denturism contend that its legalization in the United States will make a major contribution toward solution of the unmet denture needs of the elderly and the population as a whole, thereby relieving an enormous amount of human suffering and discomfort and elevating the quality of life for many elderly.

Opponents of denturism claim that the underlying problems are being dealt with responsibly by the profession and that the introduction of denturism will degrade the quality of denture care available to the elderly (and to the public at large) and may seriously jeopardize the public's oral health.

Edentulousness rates in the U.S. are steadily declining. Fluoridation, improved preventive dentistry and a greater emphasis on prevention by the dental profession have probably all contributed to this trend, which is expected to continue. In various parts of the country the dental profession has promoted programs to decrease denture care prices. On the other hand, while the *rate* of edentulousness has been declining, the total *number* of edentulous persons has been increasing somewhat. Therefore, edentulousness is expected to remain a significant public health problem, at least for some time.

Denturism is an important public health issue facing the elderly today, is being debated in many states, and is currently

*Unless otherwise noted, all statistics cited in this paper come from one of two sources: (1) Edentulous Persons, United States, 1971. Vital and Health Statistics, Series 10, No. 89. DHEW Publication No. (HRA) 74-1516; (2) Unpublished data from the Health and Nutrition Examination Survey performed 1971 to 1973 by the National Center for Health Statistics, DHEW (known as the "HANES" data).

the subject of a Federal Trade Commission investigation of state restrictions on the offering of dental care.

C. *Importance of Dental Care*

The importance of the availability of economical and convenient complete denture care to the elderly must be assessed, and its relative priority compared to other health care needs of the elderly. Little is known about the extent to which lack of adequate dental care causes or contributes to other serious health problems. However, it is known that 62 percent of people 65 and over have not seen a dentist in more than two years.

D. *Consumer Factors*

The following factors help account for statistics which show that the elderly suffer from substantial unmet denture care needs:

- the price of denture care;
- difficulty of access to a dentist because of location or office hours;
- lack of adequate information about the availability or terms of offered denture care;
- dissatisfaction with the quality of denture care offered by dentists;
- physical or mental infirmities; and
- apathy or demoralization.

These and other factors must be examined according to their relative priority for adequate denture care delivery. The following developments are likely to increase significantly the number and percentage of elderly who obtain denture care:

- a significant decrease in the price of complete denture care;
- the availability of more information, through advertising or other means, about the availability and terms of offered denture care;
- the location of more denture care providers, at sites convenient to rural and inner city elderly, who offer services during a broader range of hours than is now common; and
- special programs designed to bring denture care to the elderly (e.g., mobile denture care facilities or visiting dentists).

E. *Alternatives*

If denturism is to be discouraged or opposed, alternative strategies and measures should be pursued to relieve the unmet denture needs of the elderly. The following should be among those seriously considered:

- more public funding for denture care for the elderly;
- promotion of federal and state laws encouraging more competition within the dental profession; and
- encouragement through community action to the dental profession urging greater efforts to solve the problem.

F. *Legislation/Regulation*

If competition among providers of dental care is desirable, the role of the federal, state and local governments in creating a favorable competitive environment should be defined. Laws condoning a range of quality in competent denture care with a broader choice of price may address the problem. However, proposed measures designed to deal with the problems of denture care for the elderly should be assessed according to their appropriateness for action in the public and/or private sectors.

G. *Safeguards*

If denturism is to be encouraged or supported, minimal safeguards to the public health should accompany its introduction. The following should be among those seriously considered:

- state licensing provisions for denturists authorizing a new class of professionals under stated standards;
- dentist oral health certificates as a prerequisite to denturist denture care;
- severe sanctions for negligent denture care by nondentists; and
- certificates of proper care by a dentist following denturist treatment.

II. NURSE PRACTITIONERS

The Problem

One way to expand the availability of health care services to the aging, and perhaps decrease the cost of those services without lessening quality of care, may be to encourage the training and utilization of nurse practitioners. Nurse practitioners are registered nurses who have received advanced training which enables them to perform an expanded role in the delivery of health care services. These practitioners are capable of providing many services traditionally performed only by primary care physicians, such as:

- physical examinations;
- lab tests;
- diagnoses; and
- general management of patient therapy and health care.

Nurse practitioners generally practice in collaboration with physicians in clinics or hospital settings so that the physician is available to the nurse practitioner for consultation and referrals. Some also serve in non-metropolitan and medically underserved areas.

There are approximately 14,000 certified nurse practitioners in the United States. As a group, nurse practitioners, and particularly geriatric nurse practitioners, can be especially useful in providing primary medical care to ambulatory adult patients. Some studies indicate that nurse practitioners can manage not only nursing problems but some specific medical conditions as well. In particular, nurse practitioners have shown success in managing certain health conditions (such as diabetes, hypertension, and heart disease) which affect the aging.

Moreover, studies show that nurse practitioner practice involves more direct and continuous patient contact than physician practice and results in high quality care. In addition, according to some reports, geriatric nurse practitioners, whether by training or inclination, are more likely to become involved in areas of particular importance to the aged, such as hygiene, ability to function to the ultimate of limited capacity, and the psychological problems of adjusting and aging.*

A number of public and private restraints prevent nurse practitioners from performing the expanded functions for which their advanced education trains them or from providing primary care directly to patients except when there is direct physician supervision. In many states, statutes authorize various state regulatory boards to enact regulations defining the nurse practitioners' expanded scope of practice. Often these boards are composed of competing health care providers who may place limits on the scope of nurse practitioners' practice and restrict the ability of physicians to hire nurse practitioners where there is less than close physician supervision.

There is a great need to examine these restraints to determine their impact on the cost and quality of health care services as well as their effect on the availability and accessibility of care. To the extent that nurse practitioners are restricted from competing with doctors, older Americans are being deprived of a choice of health care provider. In addition, this restraint on competition may keep health care prices artificially high. On the other hand, the justification for these restraints is that they are necessary to protect the public health and welfare and provide quality health care. As discussed earlier, however, studies show that the quality of care by nurse practitioners is as good as that provided by physicians for the same range of services and procedures.

Attention should be focused on current health care delivery systems and the impact that expanded use of nurse practitioners would have on health care costs, and the overall quality, accessibility and availability of health care to the growing

*Lowenthal, G., and Breitenbucher, R., The Geriatric Nurse Practitioner's Value in a Nursing Home, Geriatrics 87, 91 (1975).

aged population. The role that nurse practitioners serve and the way they could best be used to improve the health care delivery systems should also be examined. In addition, attention should be specifically directed to restrictions, both governmental and private, that prevent nurse practitioners from adequately performing up to their capabilities based on educational background and professional experience.

The Issues

A. Availability of Primary Health Care

Current health care systems may soon be unable to handle the increased demands of all Americans. More specifically, our health care delivery systems must be adequately suited to meet the needs of a growing elderly population.

Studies show that physician extenders could have a substantial impact on the provision of health care by increasing physician productivity and improving the capability of an employment setting to deal more efficiently with greater numbers of patients and their special needs. Increased utilization of nurse practitioners could increase the availability of health care to the elderly.

It has been asserted that nursing home patients are underserved by physicians and that, as a rule, physicians do not enjoy working in nursing homes. Moreover, many elderly go without health care because it is not readily available or accessible.

Nurse practitioners might be used to fill the gap left by physicians if the elderly were more likely to use their services. For this to occur the use of nurse practitioners must be encouraged by state or local governments.

B. Training of Nurse Practitioners

Federal appropriations are used to help fund nurse practitioner training and education programs. However, with the increased needs for health care services among the elderly, there is also a need for more training and education on their unique health care problems. Increased federal funds could be specially authorized to develop graduate programs in geriatrics and gerontology. States might be called upon to sponsor or help fund training programs in gerontology and geriatrics. If the federal and/or state governments play a role in promoting nurse practitioner and physician involvement in the health care of older Americans, they will have to determine which agencies are best suited to deal with these specialized health care issues and which methods are the best to employ. The training of nurse practitioners and others to serve the health needs of the elderly should be examined using figures that project an oversupply of physicians that might reach 140,000 by 1990.

C. Health Care Costs

The continued upward spiral of general health care costs places an increased financial burden on the elderly population. In 1979, the per capita health bill for persons over 65 was 3 and one-half times that for persons under 65. Increasing costs restrict the elderly's access to needed health services. The expansion of the use of nurse practitioners might reduce the cost of health care services. To the extent that nurse practitioners focus on preventive and chronic care and health maintenance, which is often not covered by insurance or Medicare, the expanded use of less costly nurse practitioner services could have a tremendous beneficial impact on the aged. Moreover, increased availability of low cost preventive and chronic care could decrease the incidence of major acute health problems and further reduce total health costs. While many health care providers assert that expanded use of nurse practitioner services would reduce health care costs, there are few statistically sound studies on the impact of nurse practitioners on the cost of health care services.

D. Health Insurance

Some commentators criticize Medicare and other health insurance programs for being crisis-oriented and biased toward

acute, episodic and hospital-based care. This system, therefore, does not adequately cover disease prevention, health maintenance, or ambulatory services. The elderly need access to treatment for illness as well as access to health services which will keep them active and in good health. Currently, however, Medicare only covers 38 percent of the elderly's total health bill. The expansion of Medicare to cover chronic and preventive care and health maintenance warrants study and evaluation regarding the value and costs of such changes.

Nurse practitioners are specially trained for the type of health maintenance, education, counseling and preventive care that is so important to the elderly. Coverage of services provided by nurse practitioners might encourage health professionals to get advanced training in gerontology and geriatrics. If Medicare were broadened to include the services of nurse practitioners outside the hospital or nursing home setting it might increase the willingness of physicians to hire nurse practitioners. Private insurers could be encouraged to broaden coverage to include services provided by nurse practitioners, particularly chronic and preventive care.

Another problem with Medicare is that it only reimburses for services provided under the personal and direct supervision of physicians. This requirement limits the use of nurse practitioners and other physician extenders in medically underserved areas where there are few physicians. If Medicare regulations were changed to relax physician supervision requirements, the level of supervision necessary to ensure quality health care services must be determined.

There may be other requirements of Medicare which inhibit the use of physician extenders. These requirements need to be identified and studied along with the issues listed above to determine the cost implications in expanding the Medicare Program and the political realities for enacting these changes.

E. Health Services in Medically Underserved Areas

Many of American's elderly live in areas which do not have an adequate supply of physicians to handle health problems. The available data indicates that nurse practitioners and other physician extenders are more likely to locate in rural and other medically underserved areas. However, these alternative health care providers cannot practice if they cannot get paid for their services. Medicare requirements do not provide for reimbursement without direct physician supervision. Moreover, the scope of practice definitions for states also restrict the ability of physician extenders to practice in medically underserved areas.

In 1977, Congress passed the Rural Health Clinic Services Act which provides reimbursement for the services of nurse practitioners and physician assistants who work in specially certified rural health clinics. However, these practitioners are still subject to state scope of practice restrictions, such as direct physician supervision requirements. To date, very few clinics have become certified under the Act. Appropriate amendments to state laws could expand the ability of nurse practitioners to function in medically underserved areas.

F. State Scope of Practice Laws

Even with increased funding of gerontological and geriatric nursing programs, nurse practitioners can only provide care to the extent they are authorized by state laws. If the scope of nursing practice definitions is unduly restrictive, nurse practitioners will not be able to practice to the full extent of their training. Requirements of substantial physician supervision or prohibitions on acts of medical diagnosis and treatment or the prescription of drugs reduce the benefits of increased use of nurse practitioners by escalating costs and restricting their ability to practice. The problems with state regulations and methods by which these regulations can be changed merit attention. Changes in state

regulation should encourage full and effective use of nurse practitioners while protecting the state's legitimate quality of care concerns. A thorough evaluation of different scope of practice definitions by a qualified organization could be undertaken to determine the impact on cost, availability, accessibility and quality of care.

G. Research and Study

The aging have unique health care needs. Frequently, symptoms of disease and response to treatment are different in elderly persons than in younger patients. This can lead to incorrect diagnosis, inappropriate treatment and a potential risk to health. Much of the research on health care involves studies of younger patients and therefore may not be a reliable basis for determining health care treatment for the aging. More health care studies on specific problems of the elderly should be encouraged. The National Institute on Aging of the National Institutes of Health, the division of the Department of Health and Human Services which already is involved in studying health and the aging process, could be authorized to conduct further research in this area. Other agencies or private groups which have expertise and involvement in this area should be identified and used for further appropriate research efforts.

RECOMMENDATIONS

The following section contains the resolutions that were developed and adopted by work group delegates at the mini-conference.

Resolution Topic: AVAILABILITY OF HEALTH-RELATED SERVICES

Statement of Recommendation: Be it resolved that:

1. The following services should be made available and fully reimbursed by public funding, and all third-party sources should also be encouraged to reimburse: preventive services (including but not limited to immunizations, nutrition counseling and nutritional supplementation, physical exams, screening tests, foot exams, and vision and hearing tests); health maintenance; care of chronic conditions; podiatry; dental, optical, and audiology services; mental health services and coordination of social services.
2. In order to provide coordination of services, support should be increased for community health centers, rural health centers, urban health centers, etc. These centers should be directed to provide coordinated health services for the elderly. Increased support for hospital-based ambulatory geriatric centers and the expansion of voluntary service agencies to more comprehensive services should also be encouraged.
3. Increased support should be provided for senior citizen programs, mutual aid groups, meals on wheels, and other such programs.

Resolution Topic: INCREASING THE ABILITY OF THE ELDERLY TO REMAIN AT HOME AND WITHIN THE COMMUNITY

Statement of Recommendation: Be it resolved that:

1. The support services for families caring for disabled elderly at home should be broadened through expansion of programs of home health aides, trained homemakers, hot lines, and continuing education for families of the homebound.

2. Direct financial support for these services should be established. Tax credits should be given to families that maintain disabled elderly within the home. Senior citizen centers, day care centers, mutual aid groups, and meals on wheels should receive increased support.
3. The Administration on Aging-National Clearinghouse on Aging should be instructed to prepare a series of booklets in multiple languages covering care of homebound and health issues for the elderly consumer.
4. Increased support should be given to health-related facilities and congregate housing for elderly.

Resolution Topic: REMOVAL OF BARRIERS TO ACCESS FOR ALL HEALTH SERVICES

Statement of Recommendation: Be it resolved that:

1. The federal government should continue to support rural health clinics, urban community health centers and hospital-based ambulatory centers to provide health care by a full range of health providers.
2. A system of transportation should be established to transport patients (elderly and disadvantaged) to the nearest appropriate medical facility for primary care as well as emergency care. This should include reimbursement for mobile services or outreach services from a clinic or hospital. The Internal Revenue Service should be mandated to allow as deductible items transportation for patients and their families.
3. The federal government should be encouraged to continue the National Health Service Corps as an agent for promotion of health services for rural and urban communities designated as underserved areas.
4. Medicare (Title XVIII) should be mandated by regulation to reimburse for nurse practitioners and/or physician assistant services.
5. States should be encouraged to allow nurse practitioners and physician assistants to practice under appropriate laws or regulations.
6. The federal government, through health and social services, should provide for translation services for ethnic groups who cannot communicate in English.
7. The federal government, by tax credit and/or special reimbursement, should encourage architectural renovation to provide access to private offices for handicapped persons.
8. Federal and state health service programs should be encouraged to select a greater number of applicants from rural and urban areas and minority groups since these individuals are most likely to provide services in the future for the medically underserved.

Resolution Topic: COST REIMBURSEMENT AND FINANCIAL ACCESS TO PRIMARY HEALTH CARE

Statement of Recommendation: Be it resolved that:

1. A system should be developed for the publication of a medical directory of physicians, their specialties and standard charges.
2. The present reimbursement system should be canceled and a more equitable system of medical reimbursements developed.
3. Nurse practitioners should be reimbursed directly for primary care provided under the care of licensed physicians.
4. State insurance commissioners should be urged to encourage third-party insurers to comply with (2) and (3) above.

5. Any physician serving any person entitled to Medicare benefits should be required to accept the new equitable reimbursement rates as full payment.

Minority Opinion: Physicians who take assignment should have to accept the new rates as full payment; but those physicians who do not take assignment should not be required to accept these rates as full payment.

Resolution Topic: BARRIERS TO THE ENTRY OF NEW PROVIDERS

Statement of Recommendation: Be it resolved that:

1. States should review the criteria on the admission of out-of-state physicians into practice within the state.
2. States should be encouraged to pass laws permitting the practice of nurse practitioners or other alternate health care providers, assuring that such laws assure adequate quality of practice in those fields.

Resolution Topic: IMPROVED EDUCATION ON THE MEDICAL NEEDS OF THE ELDERLY

Statement of Recommendation: Be it resolved that:

1. Medical training in both continuing and primary courses should include treatment and care of the elderly. Local and state medical societies should be encouraged to provide this educational component.

Appendix A

Delegates for White House Conference on Aging
Mini-Conference on Consumer Problems of Older Americans

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APPENDICES

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J. Barry Mason Board of Visitors Research Professor Chair, Management and Marketing University of Alabama Box J University, AL 35486 (205) 348-6183	Credit
Edward J. McDonnell Director Division of Compliance Programs Bureau of Medical Devices Food and Drug Administration 8757 Georgia Avenue Silver Spring, MD 20910 (202) 427-8120	Prescription Drugs and Medical Appliances
Joseph C. Mike Insurance Commissioner State of Connecticut Insurance Department P.O. Box 816 Hartford, CT 06115 (203) 566-5275	Insurance
Dr. Sanford Miller Director, Bureau of Foods Food and Drug Administration 200 C Street, S.W. Washington, D.C. 20204 (202) 245-8850	Food

NAME/ADDRESS	WORK GROUP
Joel Minsker Suite 511, Biscayne Building 19 West Flagler Street Miami, FL 33130 (305) 374-1177	Investments
Marsha Muske Supervisor, Complaint Handling Unit Consumer Frauds and Crimes Office of the Attorney General 30 East Broad Street Columbus, OH 43215 (614) 466-4986	Investments
Sarah H. Newman Vice President, National Consumer League 1411 Hopkins Street, N.W. Washington, D.C. 20036 (202) 785-1438	Prescription Drugs and Medical Appliances
Jeanie Owen-Miller Assistant Director for Consumer Protection Office of the Attorney General Division of Consumer Protection 209 St. Clair Frankfort, KY 40601 (502) 564-6607	Insurance
Michael R. Pollard Health Policy Coordinator Federal Trade Commission Washington, D.C. 20580 (202) 523-1576	Primary Health Care Providers
Florence Rice Harlem Consumer Education Council 540 W. 158th Street New York, NY 10032 (212) 926-5300	Food
Lee Richardson Consumer Affairs Consultant P.O. Box 1106 Columbia, MD 21044 (301) 596-4899	Insurance
Christina Robb Asociacion Nacional Pro Personas Mayores 1424 K Street, N.W., Suite 602 Washington, D.C. 20005 (202) 393-2206	Investments

NAME/ADDRESS	WORK GROUP
Dorothy V. Ryan President, Ohio State Council of Senior Citizens and President N.E. Ohio Senior Citizens Council 3548 Cardinal Drive Youngstown, OH 44505 (216) 759-0866	Prescription Drugs and Medical Appliances
Shiela Sidles Iowa Consumers League Rural Route #1 Centerville, IA 52544 (515) 872-2329	Food
Daniel W. Sigelman Staff Attorney Health Research Group 2000 P Street, N.W., Room 708 Washington, D.C. 20036 (202) 872-6320	Primary Health Care Providers
R. Frances Smith Member of the Board, National Retired Teachers Association 2201 E. Kleindale Tucson, AZ 85719 (602) 325-0556	Insurance
Robert L. Snively Community Pharmacist Chairman, APHA Long Term Care Section 101 E. Market Street Georgetown, DE 19947 (302) 856-2015	Prescription Drugs and Medical Appliances
Donald C. Snyder, Ph.D. Goucher College 706 Boundary Avenue Silver Spring, MD 20917 (301) 825-3300	Food
John R. Stone Vice President Combined Insurance Company of America 5050 N. Broadway Chicago, IL 60640 (312) 275-8000	Insurance
David A. Swankin Swankin and Turner Consumer Law Firm 1625 Eye Street, N.W. Suite 923 Washington, D.C. 20006 (202) 872-8660	Insurance

NAME/ADDRESS	WORK GROUP
Dr. Alice B. Tobler Consultant to State Department of Health and Mental Hygiene 13801 York Road H-5 Cockeysville, MD 21030 (301) 628-7576	Primary Health Care Providers
D. Martin Trueblood Member, American Association of Homes for the Aged House of Delegate, Executive Director Broadmead 13801 York Road Cockeysville, MD 21030 (301) 628-6900	Primary Health Care Providers
Belle Whaley Operation Brotherhood 2135 S. Central Park Avenue Chicago, IL 60623 (312) 522-0433	Food
Toba Winston Medigap Operations Staff Health Care Financing Administration 6401 Security Boulevard, Room 555 E. High Rise Building Baltimore, MD 21235 (301) 594-6640	Insurance

Appendix B

Resources

This limited resource list has been compiled to direct the interested reader to further sources of information on the issues discussed in this book.

GENERAL INFORMATION

Bureau of Consumer Protection
U.S. Federal Trade Commission
Washington, D.C. 20580

The FTC has regional offices in Atlanta, Boston, Chicago, Cleveland, Dallas, Denver, Los Angeles, New York, San Francisco and Seattle.

Consumers Union
256 Washington Street
Mount Vernon, New York 10550

Consumer Federation of America
1314 14th Street, N.W.
Washington, D.C. 20005

National Retired Teachers Association
American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20049

Local offices of the Better Business Bureau can provide helpful information about businesses and services in their cities.

National and local offices of organizations including: League of Women Voters; National Council of Senior Citizens; Gray Panthers; etc. are repositories of information on many of the issues highlighted in this book.

CREDIT

Local non-profit credit counseling organizations can usually provide helpful information. The key word here is "non-profit," since these are the groups that have been set up to provide specific consumer oriented services without charging high fees or having ties to specific business interests. Local chapters of some of the organizations listed under "General Information" above may be able to assist in locating a qualified non-profit credit counseling service in their cities.

Local chapters of the National Organization for Women and other women's groups often provide credit counseling for married and formerly married women that is especially useful to older women who belong in either category.

National Organization for Women
(Headquarters)
425 13th Street, N.W.
Washington, D.C. 20004

Office of Consumer and
Compliance Programs
Federal Deposit Insurance Corporation
550 17th Street, N.W.
Washington, D.C. 20429

Consumer and Community Affairs Office
Federal Reserve Board
20th and C Streets, N.W.
Washington, D.C. 20551

FOOD

Nutrition information is available through:

Food and Nutrition
Extension Service
U.S. Department of Agriculture
Room 5404 South
Washington, D.C. 20250

Center for Science in the Public Interest
1755 S Street, N.W.
Washington, D.C. 20009

Food Marketing Institute
1750 K Street, N.W., Suite 800
Washington, D.C. 20006

Information on issues discussed in the Food Section of this book is available through:

Community Nutrition Institute
1146 19th Street, N.W.
3rd Floor
Washington, D.C. 20036

INSURANCE

National Insurance Consumer Organization
344 Commerce Street
Alexandria, Virginia 22314

Information is also available from state insurance commissions and various insurance trade associations.

INVESTMENTS

International Franchise Association
1025 Connecticut Avenue, N.W.
Washington, D.C. 20036

Inform
25 Broad Street
New York, New York 10004

This non-profit organization has written in-depth reports on certain major subdivisions and conducts research on land development.

Office of Interstate Land Sales
U.S. Department of Housing and Urban Development
Washington, D.C. 20410

State Attorneys General Offices in states where investment opportunity is located, and local offices of registration for subdivision offerings (the title of this office will vary from state to state) can provide useful information.

PRESCRIPTION DRUGS AND MEDICAL APPLIANCES

American Pharmaceutical Association
2215 Constitution Avenue, N.W.
Washington, D.C. 20037

National Association of Chain Drug Stores
413 North Lee Street
Alexandria, Virginia 22314

American Speech, Language and Hearing Association
10801 Rockville Pike
Rockville, Maryland 20852

American Council of Otolaryngology
1100 17th Street, N.W.
Washington, D.C. 20036

National Hearing Aid Society
20361 Middlebelt Road
Livonia, Michigan 48152

This organization can provide information listing the sellers of hearing aids in different areas.

American Optometric Association
243 North Lindbergh Boulevard
St. Louis, Missouri 63141

American Academy of Opthamology
1750 K Street, N.W.
Washington, D.C. 20006

Opticians Association of America
1250 Connecticut Avenue, N.W.
Washington, D.C. 20036

American Foundation for the Blind
15 West 16th Street
New York, New York 10011

PRIMARY HEALTH CARE PROVIDERS

National Denturist Association
11 South LaSalle Street
Chicago, Illinois 60603

American Nurses Association
2420 Pershing Road
Kansas City, Missouri 64108

American Academy of Physician Assistants and Association of Physician Assistant Programs
2341 Jefferson Davis Highway
Suite 700
Arlington, Virginia 22202

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Consumer Federation of America
Gray Panthers
National Association of Area Agencies on Aging
National Association of Consumer Agency Administrators
National Association of State Units on Aging
National Caucus on the Black Aged
National Consumers League
National Council on Aging
National Council of Senior Citizens
Society of Consumer Affairs Professionals in Business
Society of Consumer Affairs Professionals in Business, Washington, D.C. Chapter
Esther Peterson, former Special Assistant to the President for Consumer Affairs and former Director, U.S. Office of Consumer Affairs

Guidance and Assistance

Federal Trade Commission
U.S. Department of Agriculture
U.S. Food and Drug Administration
U.S. Office of Consumer Affairs

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Consumer Affairs Section
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National Retired Teachers Association
American Association of Retired Persons

1909 K Street, N.W.
Washington, D.C. 20049

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